DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

PROPERTY AND CASUALTY

3 CCR 702-5

[Editor's Notes follow the text of the rules at the end of this CCR Document.]

Regulation 5-1-1 MASS MERCHANDISING OF PROPERTY AND LIABILITY INSURANCE

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § 10-1-109, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to prescribe rules to prevent abuses in connection with the sale of property and liability insurance in this state pursuant to mass marketing plans, while preserving for consumers the potential benefits of this form of marketing.

Section 3 Applicability

This regulation is in addition to, and not a substitution for, other applicable requirements of the Colorado insurance laws. It is not applicable to group life or group accident and health insurance or to marketing methods other than mass merchandising as defined herein.

Section 4 Definitions

As used in this regulation:

A. "Mass merchandising" means the marketing of property and liability insurance through the sponsorship and assistance of an eligible group for the benefit of the eligible members thereof.

B. "Property and liability insurance" means all insurance to which the provisions of § 10-3-102(1)(a) and (c), C.R.S., apply.

C. "Group property and liability insurance" means all property and liability insurance issued to an eligible group for the benefit of the eligible members thereof, under a single insurance program, without individual underwriting, on a guaranteed issue basis, subject to the provisions of Section 5.

D. "Non-group property and liability insurance" means all property and liability insurance issued to individual members of an eligible group, with individual underwriting for determination of proper premium rates, on a guaranteed issue basis, subject to the provisions of Section 6.

E. "Eligible group" means any organization or association of persons which has not been organized principally for the purpose of obtaining insurance under a mass merchandising plan. An eligible group may consist of members of a union, employees of a common employer, members of an association, and the like, or any class or classes thereof, as determined by the conditions pertaining to employment or membership. Any such association must have been in existence for at least two (2) years prior to the purchase of insurance under a mass merchandising plan.

F. "Eligible members" means all the employees and retirees of a common employer or members, in good standing, of an eligible group.

G. "Employees" means all active employees of a common employer, including proprietors, partners and directors, who are engaged in at least thirty (30) hours of employment per week. The term may apply to one or more subsidiaries or affiliates.

H. "Eligible member insured" means an eligible member of an eligible group who is provided insurance coverage under a mass merchandising plan.

Section 5 Mass Merchandising of Group Property and Liability Insurance

Group property and liability insurance may be issued in Colorado under a mass merchandising plan provided the following conditions are complied with:

A. At the inception date of the group mass merchandising plan, the group must consist of at least 50 eligible members of which at least 50% said eligible members must agree in writing to participate in the mass merchandising plan at the expiration of existing insurance. At all times thereafter at least 50% of all eligible members must participate in the mass merchandising plan.

B. Insurance coverage must be provided to all eligible members of the eligible group desiring to participate in the mass merchandising plan, unless at least one of the reasons for cancellation or nonrenewal listed in paragraph A of Section 7 is known to exist.

C. Each eligible member insured must be issued the same form of policy, varying only as to the amounts of insurance coverage and limits of liability; except that, in the case of automobile insurance, uniform limits for bodily injury and property damage perils may be established and uniform comprehensive, collision and other supplemental coverages may be made optional.

D. Insurance must be provided either by individual policies, or individual certificates issued under a master policy and subject to the same terms and conditions as therein contained, to each subscribing member of the group.

Section 6 Mass Merchandising of Non-Group Property and Liability Insurance

Non-group property and liability insurance may be issued in this state under a mass merchandising plan providing the following conditions are complied with:

A. All subscribing members must be eligible members of an eligible group, but the provisions of paragraph A of Section 5 regarding the minimum number of eligible members and percentage of participation shall not apply to mass merchandising of non-group property and liability insurance.

B. Insurance coverage must be provided to all eligible members of the eligible group desiring to participate in the mass merchandising plan at a premium rate based upon the applicant's proper classification unless at least one of the reasons for cancellation or nonrenewal listed in paragraph A of Section 7 is known to exist.

C. Insurance must be provided by individual policies to each subscribing member.

Section 7 Cancellation and Non-Renewal

A. Insurance coverage provided an eligible member insured under a mass merchandising plan for any line of business may be canceled or nonrenewed pursuant to Colorado insurance laws and regulation and the terms of the insurance contract.

B. All mass marketing plans shall provide the eligible member insured under such plan with an opportunity to purchase individual equivalent coverage from the same insurer or one of its affiliates upon termination of employment or membership or upon the discontinuance of the mass marketing plan. The failure of the eligible group to remit premiums when due shall not be regarded as non-payment of premium by an eligible member insured under any mass merchandising plan, unless such insured shall have been given written notice of such failure to remit and has not paid such premium by the later of: (a) thirty (30) days after such notice; or (b) the due date of such premium remittance under the mass merchandising plan.

C. Any notice of cancellation or non-renewal of any coverage of an eligible member insured under a non-group property and liability insurance plan shall be accompanied by a notice that, at his or her request, the insurer will afford a reasonable opportunity to the eligible member insured and/or the eligible group to present facts in opposition to cancellation or non-renewal.

Section 8 Conversion

A. Every policy of mass merchandised property and liability insurance shall contain a provision that if the eligible member insured's employment or membership in the eligible group is terminated or if the mass merchandising plan is terminated, the eligible member insured shall be entitled to:

1. Continue his or her insurance coverage at the then existing premium rate for thirty (30) days after such termination upon payment of the premium; and

2. After the expiration of the 30 day period, the insurer, or one of its affiliates, if any, shall provide the eligible member insured an individual policy affording the same or similar coverage. The insured shall return the application, provided by the insurer and payment of premium within the thirty (30) day period provided above, providing the member insured is qualified for insurance coverage under any insurance program currently filed by the insurer or any of its affiliates, with the Colorado Division of Insurance; or

3. If such person is not so eligible for insurance coverage with the insurer or its affiliates, the insurer shall render him or her all reasonable assistance to obtain insurance from other sources. As to motor vehicle insurance coverage, the insurer's assistance will include, where applicable, making available and processing an application for the Colorado Motor Vehicle Insurance Plan, if so desired by the applicant.

B. The premium for any individual insurance policy issued by the insurer pursuant to this section shall be at the insurer's then customary rate applicable to the coverage provided and to the class of risk to which the insured belongs on an individual basis.

C. The failure of the eligible member insured to exercise his or her conversion privileges under this Section shall be treated as a voluntary termination of the coverage by the eligible member insured.

Section 9 Maintenance of Records

Every insurer writing insurance under mass merchandising plans shall keep and maintain separate statistics for each classification of insurance within such plans, to include but not limited to complete records of premium income, losses and expenses, and adding thereto appropriate expense factors for acquisition, advertising, tax liabilities, legal, accounting, data processing and research and development expense. Said statistics from each of the above-listed factors shall be used to promulgate the premium rates and rating plans and to insure that the costs of the mass merchandising plans are in no way transferred to the rates of individuals who are not insured under such plans.

Section 10 Premium Rates

Premium rates under a mass merchandising plan must not be excessive, inadequate or unfairly discriminatory. Rates shall not be deemed to be unfairly discriminatory because different premiums result for policyholders with like exposures, but different expense factors, or like expense factors, but different loss exposures, so long as the rates reflect the difference with reasonable accuracy. Rates shall not be deemed to be unfairly discriminatory if they are averaged broadly among persons insured under a mass merchandising plan.

Section 11 Experience Rating

Experience rating must be applied to any eligible group based on the experience of that group during the preceding insurance year or years.

Section 12 Producers

No person shall act as an insurance producer in connection with any mass merchandising plan for any kind of insurance unless such person is duly licensed as a producer for such kind of insurance. For the purposes of this regulation, the following activities, if performed by the sponsoring eligible group, shall not require a producer's license:

A. Collection and remittance of premium.

B. Distribution to eligible members of insurer prepared information pertaining to the mass merchandising plan.

C. Administrative services in connection with the mass merchandising plan.

Section 13 Compulsory Participation Prohibited

No employee or member shall be subject to any penalty, coercion, intimidation, or be discriminated against because of nonparticipation in any mass merchandising plan.

Section 14 Tie-In Sales Prohibited

No insurer shall sell insurance pursuant to a mass merchandising plan if the purchase of insurance available under such plan is contingent upon the purchase of any other insurance, product or service, or if the purchase or price of any other insurance, product or service is contingent upon the purchase of insurance available under such plan. This provision shall not be deemed to prohibit the reasonable requirement of safety devices, such as heat detectors, lightning rods, theft prevention equipment, and the like.

Section 15 Disclosure Required

Every insurer or producer selling insurance, pursuant to a mass merchandising plan shall, prior to sale, provide full and fair disclosure to all prospective eligible member insureds, of all essential features of such plan, whether favorable or unfavorable, including, but not limited to, premium rates, benefits, duration of coverage, conversion privileges, and policyholder services.

Section 16 Severability

If any provisions of this regulation or its application to any person or circumstances are for any reason held to be invalid, the remainder of the regulation shall not be affected in any way.

Section 17 Enforcement

Non compliance with this Regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of fines, issuance of cease and desist orders, and/or suspensions or revocation of insurance license.

Section 18 Effective Date

This regulation is effective on June 1, 2012.

Section 19 History

Originally issued as Regulation 72-8, effective April 1,1972.

Renumbered as Colorado Regulation 5-1-1 on June 1,1992.

Amended Regulation effective January 1, 2002.

Amended Regulation effective April 1, 2002.

Sections 2, 3, 7, 18 and 19 amended effective February 1, 2004.

Sections 7 and 18 amended effective January 1, 2005.

Amended regulation effective July 15, 2011.

Amended regulation effective June 1, 2012

Regulation 5-1-2 APPLICATION AND BINDER FORMS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § § 10-1-109 and 10-3-1110, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to implement rules that provide clear disclosure of the insurance company on the application form or on the binder. In addition, this regulation is designed to eliminate the

unfair practice of providing false or misleading information by individuals who are not disclosing the name of the insurance company on an application form or a binder for insurance.

Section 3 Applicability

This regulation shall apply to all property and casualty insurance coverage lawfully issued and delivered in the State of Colorado, except surplus line risks or insurance under the Colorado Motor Vehicle Insurance Plan under § 10-4-412, C.R.S.

Section 4 Definitions

A. "Binder" means a writing which describes the subject and amount of insurance and temporarily binds insurance coverage pending the issuance of an insurance policy.

B. "Application" shall include any application form or enrollment form for coverage under any policy.

Section 5 Rules

A producer shall clearly disclose the name of the insurance company on all applications, binders, and similar forms that will be used to insure the risk prior to the time the policy reaches the applicant.

Section 6 Severability

If any provision of this regulation or the application or it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 8 Effective Date

This regulation is effective on July 1, 2012.

Section 9 History

Regulation 74-9, was effective 1974.

Regulation 74-9 was renumbered as Regulation 5-1-2, effective July 1, 1993.

Regulation 5-1-2 was repealed and revised effective December 1, 2001.

Amended regulation effective July 1, 2012.

Regulation 5-1-6 NATIONWIDE INLAND MARINE DEFINITION

Section 1 Authority

Section 2 Scope and Purpose

Section 3 Applicability

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § 10-1-109, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to adopt a standard definition of "inland marine" insurance.

Section 3 Applicability

This regulation shall apply to all property and casualty insurance coverage lawfully issued and delivered in the State of Colorado.

Section 4 Rules

A. Marine or transportation policies may provide coverage under the following conditions:

1. Imports.

   a. Imports may be covered wherever the property may be, without restriction as to time, provided the coverage of the issuing companies includes hazards of transportation.

   b. An import, as a proper subject, or marine or transportation insurance, shall be deemed to maintain its character as such, so long as the property remains segregated in such a way that it can be identified and has not become incorporated and mixed with the general mass of property in the United States, and shall be deemed to have been completed when the property has been:

      (1) Sold and delivered by the importer, factor or consignee;

      (2) Removed from place of storage and placed on sale as part of importer's stock in trade at a point of sale-distribution; or

      (3) Delivered for manufacture, processing or change in form to premises of the importer or of another used for any such purposes.

2. Exports.

   a. Exports may be covered wherever the property may be without restriction as to time, provided the coverage of the issuing companies includes hazards of transportation.

b. An export, as a proper subject of marine or transportation insurance, shall be deemed to acquire its character as such when designated or while being prepared for export and retain that character unless diverted for domestic trade, and when so diverted, the provisions of this regulation respecting domestic shipments shall apply. However, this provision shall not apply to long established methods of insuring certain commodities such as cotton.

3. Domestic Shipments.

   a. Domestic shipments on consignment, for sale or distribution, exhibit, trial, approval or auction, while in transit, while in the custody of others and while being returned, provided that in no event shall the policy provide coverage on premises owned, leased or operated by the consignor.

   b. Domestic shipments not on consignment, provided the coverage of the issuing companies includes hazards of transportation, beginning and ending within the United States, provided that the shipments shall not be covered at manufacturing premises nor after arrival at premises owned, leased or operated by insured or purchaser.

4. Bridges, tunnels and other instrumentalities of transportation and communication, excluding buildings, their improvements and betterments, furniture and furnishings, fixed contents and supplies held in storage. This includes:

   a. Bridges, tunnels, other similar instrumentalities, including auxiliary facilities and equipment attendant thereto;

   b. Piers, wharves, docks, slips, dry docks and marine railways;

   c. Pipelines, including on-line propulsion, regulating and other equipment appurtenant to the pipelines, but excluding all property at manufacturing, producing, refining, converting, treating or conditioning plants;

   d. Power transmission and telephone and telegraph lines, excluding all property at generating, converting or transforming stations, substations and exchanges;

   e. Radio and television communication equipment in use as such including towers and antennae with auxiliary equipment, and appurtenant electrical operating and control apparatus; and

   f. Outdoor cranes, loading bridges and similar equipment used to load, unload and transport.

5. Personal property floater risk covering individuals.

   a. Personal Effects Floater Policies;

   b. The Personal Property Floater;

   c. Government Service Floaters;

   d. Personal Fur Floaters;

   e. Personal Jewelry Floaters;

f. Wedding Present Floaters for not exceeding ninety (90) days after the date of the wedding;

g. Silverware Floaters;

h. Fine Arts Floaters covering paintings, etchings, pictures, tapestries, art glass windows, and other bona fide works of art of rarity, historical value or artistic merit;

i. Stamp and Coin Floaters;

j. Musical Instrument Floaters. Radios, televisions, record players and combinations thereof are not deemed musical instruments;

k. Mobile Articles, Machinery and Equipment Floaters, excluding motor vehicles designed for highway use and auto homes, trailers and semi-trailers except when hauled by tractors not designed for highway use, covering identified property of a mobile or floating nature pertaining to or usual to a household. The policies shall not cover furniture and fixtures not customarily used away from premises where the property is usually kept;

l. Installment Sales and Leased Property Policies covering property pertaining to a household and sold under conditional contract of sale, partial payment contract or installment sales contract or lease, but excluding motor vehicles designed for highway use. The policies must cover in transit but shall not extend beyond the termination of the seller's or lessor's interest; and

m. Live Animal Floaters.

6. Commercial Property Floater Risks covering property pertaining to a business, profession or occupation.

a. Radium Floaters;

b. Physician's and Surgeon's Instrument Floaters. The policies may include coverage of furniture, fixtures and tenant insured's interest in improvements and betterments of buildings located in that portion of the premises occupied by the assured in the practice of his or her profession;

c. Pattern and Die Floaters;

d. Theatrical Floaters, excluding buildings and their improvements and betterments, and furniture and fixtures that do not travel about with theatrical troupes;

e. Film Floaters, including builders' risk during the production and coverage on completed negatives and positives and sound records;

f. Salesmen's Samples Floaters;

g. Exhibition Policies on property while on exhibition and in transit to or from exhibitions;

h. Live Animal Floaters;

i. Builders' Risks or Installation Risks covering interest of owner, seller or contractor, against loss or damage to machinery, equipment, building materials or supplies, being used with and during the course of installation, testing, building, renovating

or repairing. The policies may cover at points or places where work is being performed, while in transit and during temporary storage or deposit, of property designated for and awaiting specific installation, building, renovating or repairing.

(1) Coverage shall be limited to Builders' Risks or Installation Risks where perils in addition to Fire and Extended Coverage are to be insured.

(2) If written for owner, the coverage shall cease upon completion and acceptance thereof; or

(3) If written for seller or contractor the coverage shall terminate when the interest of the seller or contractor ceases.

j. Mobile Articles, Machinery and Equipment Floaters, excluding motor vehicles designed for highway use and auto homes, trailers and semi-trailers except when hauled by tractors not designed for highway use and snow plows constructed exclusively for highway use; covering identified property of a mobile or floating nature, not on sale or consignment, or in course of manufacture, which has come into custody or control of parties who intend to use such property for which it was manufactured or created. The policies shall not cover furniture and fixtures not customarily used away from premises where the property is usually kept.

k. Property in transit to or from and in the custody of bailees, not owned, controlled or operated by the bailor. The policies shall not cover bailee's property at his or her premises.

l. Installment Sales and Leased Property. Policies covering property sold under conditional contract of sale, partial payment contract, installment sales contract, or leased but excluding motor vehicles designed for highway use. The policies must cover in transit but shall not extend beyond the termination of the seller's or lessor's interest. This section is not intended to include machinery and equipment under certain "lease-back" contracts.

m. Garment Contractors Floaters.

n. Furriers or Fur Storers Customers Policies, such as policies under which certificates or receipts are issued by furriers or fur storers, covering specified articles the property of customers.

o. Accounts Receivable Policies, Valuable Papers and Records Policies.

p. Floor Plan Policies, covering property for sale while in possession of dealers under a Floor Plan or any similar plan under which the dealer borrows money from a bank or lending institution with which to pay the manufacturer, provided:

(1) The merchandise is specifically identifiable as encumbered to the bank or lending institution;

(2) The dealer's right to sell or otherwise dispose of the merchandise is conditioned upon its being released from encumbrance by the bank or lending institution; and

(3) That the policies cover in transit and do not extend beyond the termination of the dealer's interest.

(4) These policies shall not cover automobiles or motor vehicles; merchandise for which the dealer's collateral is the stock or inventory as distinguished from merchandise specifically identifiable as encumbered to the lending institution.

q. Sign and Street Clock Policies, including neon signs, automatic or mechanical signs, street clocks, while in use as such.

r. Fine Arts Policies covering paintings, etchings, pictures, tapestries, art glass windows, and other bona fide works of art of rarity, historical value or artistic merit, for account of museums, galleries, universities, businesses, municipalities and other similar interests.

s. Policies covering personal property which, when sold to the ultimate purchaser, may be covered specifically by the owner under Inland Marine Policies including:

(1) Musical Instrument Dealers Policies, covering property consisting principally of musical instruments and their accessories. Radios, televisions, record players and combinations thereof are not deemed musical instruments.

(2) Camera Dealers Policies, covering property consisting principally of cameras and their accessories.

(3) Furrier Dealers Policies, covering property consisting principally of furs and fur garments.

(4) Equipment Dealers Policies, covering mobile equipment consisting of binders, reapers, tractors, harvesters, harrows, tedders and other similar agricultural equipment and accessories therefore; construction equipment consisting of bulldozers, road scrapers, tractors, compressors, pneumatic tools and similar equipment and accessories therefore; but excluding motor vehicles designed for highway use.

(5) Stamp and Coin Dealers covering property of philatelic and numismatic nature.

(6) Jewelers' Block Policies.

(7) Fine Arts Dealers. Policies may include coverage of money in locked safes or vaults on the insured's premises. The policies also may include coverage of furniture, fixtures, tools, machinery, patterns, molds, dies and tenant insureds' interest in improvements of buildings.

t. Wool Growers Floaters.

u. Domestic Bulk Liquids Policies, covering tanks and domestic bulk liquids stored therein.

v. Difference in Conditions Coverage excluding fire and extended coverage perils.

w. Electronic Data Processing policies.

B. Unless otherwise permitted, nothing above shall be construed to permit marine or transportation policies to cover:

1. Storage of insured's merchandise, except as previously provided;

2. Merchandise in course of manufacture, the property of and on the premises of the manufacturer;

3. Furniture and fixtures and improvements and betterments to buildings; or

4. Monies or securities in safes, vaults, safety deposit vaults, bank or insured's premises, except while in the course of transportation.

Section 5 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 6 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspension or revocation of license, subject to the requirements of due process.

Section 7 Effective Date

This regulation shall become effective on September 1, 2012.

Section 8 History

New regulation 78-14, effective 1978.

Amended regulation effective July 1, 1993.

Amended regulation effective March 1, 1994.

Amended regulation effective January 1, 2006.

Amended regulation effective September 1, 2012.

Regulation 5-1-8 CONCERNING CLAIMS-MADE INSURANCE POLICIES

Section 9 History

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of §10-1-109, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish standards for the training of all persons engaged in the sale or consultation of claims-made policies in compliance with §10-4-419(2)(g) or in adjusting claims under such policies, and to provide minimum disclosure standards for claims-made insurance policies.

Section 3 Applicability

This regulation applies to casualty insurers writing policies on a claims-made basis. This regulation does not apply to persons engaged in the sale or consultation of surplus lines claims-made insurance policies or in adjusting claims under such policies.

Section 4 Definitions

A. "Claims-made coverage" means an insurance policy that provides coverage only if a claim is made during the policy period or any applicable extended reporting period. A claim made during the policy period could be charged against a claims-made policy even if the injury or loss occurred many years prior to the policy period. If a claims-made policy has a retroactive date, an occurrence prior to that date is not covered.

B. "Extended reporting period" means a period allowing for making claims after expiration of a claims-made policy. This is also known as a "tail".

C. “Occurrence coverage" means an insurance policy that provides liability coverage only for injury or damage that occurs during the policy term, regardless of when the claim is actually made. A claim made in the current policy year could be charged against a prior policy year, or may not be covered, if it arises from an occurrence prior to the effective date.

D. "Retroactive date" means the date on a claims-made policy which denotes the commencement date of coverage under the policy.

Section 5 Rules

A. Training/Education

1. The training and certification program shall be as follows:

    a. Completion of a two-hour approved seminar devoted to claims-made policies and receipt of a certificate of completion; or

    b. Completion of an approved self-study program of claims-made policies equivalent to two hours, upon the completion of which the participant executes a certificate of completion.

2. To qualify, a seminar or self-study program must address the following topics:

    a. Differences between claims-made and occurrence policies;

b. Retroactive dates; and

c. Changing retroactive dates;

d. Extending reporting periods;

e. Coverage mechanism (trigger);

f. Aggregates; and

g. Legal defense cost provisions.

3. All persons or entities offering or planning to offer a claims-made training and certificate program shall first submit all program materials to the Colorado Division of Insurance for approval.

4. Only certificates issued to or executed by participants in approved seminars or self-study programs shall be acceptable.

5. All persons required to be certified, pursuant to §10-4-419(2)(g), C.R.S., shall keep in their permanent records the certificate of completion of the qualified claims-made program.

6. All persons required to be licensed pursuant to Part 2, Article 2 of Title 10, C.R.S., and who engage in the sale or consultation of claims-made policies must file a copy of a certificate of completion of a qualified program with the licensing section of the Colorado Division of Insurance.

7 The two-hour claims-made policy training may be counted toward the twenty-four hour continuing education requirement of insurance producers.

B. Disclosure Form

At the time of commencement of coverage either the insurer or the insurance producer shall execute a proof of delivery and acceptance of the disclosure form. The proof of delivery and acceptance shall be maintained in the insurer or producer file for at least two years beyond the term of the policy.

In connection with the sale of any claims-made policy, the insurer shall give to the insured a disclosure statement substantially in the following form:

DISCLOSURE FORM

CLAIMS-MADE POLICY

IMPORTANT NOTICE TO POLICYHOLDER

THIS DISCLOSURE FORM IS NOT YOUR POLICY. IT DESCRIBES SOME OF THE MAJOR FEATURES OF OUR CLAIMS-MADE POLICY FORM. READ YOUR POLICY CAREFULLY TO DETERMINE RIGHTS, DUTIES, AND WHAT IS AND IS NOT COVERED. ONLY THE PROVISIONS OF YOUR POLICY DETERMINE THE SCOPE OF YOUR INSURANCE PROTECTION.

YOUR POLICY

Your policy is a claims-made policy. It provides coverage only for injury or damage occurring after the policy retroactive date (if any) shown on your policy and the incident is reported to your

insurer prior to the end of the policy period. Upon termination of your claims-made policy an extended reporting period option is available from your insurer.

There is no difference in the kind of injury or damage covered by occurrence or claims-made policies. Claims for damages may be assigned to different policy periods, depending on which type of policy you have.

If you make a claim under your claims-made policy, the claim must be a demand for damages by an injured party and does not have to be in writing. Under most circumstances, a claim is considered made when it is received and recorded by you or by us. Sometimes, a claim may be deemed made at an earlier time. This can happen when another claim for the same injury or damage has already been made, or when the claim is received and recorded during an extended reporting period.

PRINCIPAL BENEFITS

This policy provides for _____ (insert brief description of coverage) up to the maximum dollar limit specified in the policy.

The principal benefits and coverages are explained in detail in your claims-made policy. Please read it carefully and consult your insurance producer about any questions you might have.

EXCEPTIONS, REDUCTIONS AND LIMITATIONS

Your claims-made policy contains certain exceptions, reductions and limitations. Please read them carefully and consult your insurance producer about any questions you might have.

RENEWALS AND EXTENDED REPORTING PERIODS

Your claims-made policy has some unique features relating to renewal, extended reporting periods and coverage for events with long periods of potential liability exposure.

If there is a retroactive date in your policy, no event or occurrence prior to that date will be covered under the policy even if reported during the policy period. It is therefore important for you to be certain that there are no gaps in your insurance coverage. These gaps can occur in several ways. Among the most common are:

1. If you switch from an occurrence policy to a claims-made policy, the retroactive date in your claims-made policy should be no later than the expiration date of the occurrence policy.

2. When replacing a claims-made policy with a claims-made policy, you should consider the following:

    a. The retroactive date in the replacement policy should extend far enough back in time to cover any events with long periods of liability exposure, or

    b. If the retroactive date in the replacement policy does not extend far enough back in time to cover events with long periods of liability exposure, you should consider purchasing extended reporting period coverage under the old claims-made policy.

3. If you replace this claims-made policy with an occurrence policy, you may not have insurance coverage for a claim arising during the period of claims-made coverage unless you have purchased an extended reporting period under the claims-made policy. Extended reporting period coverage must be offered to you by law for at least one year after the

expiration of the claims-made policy at a premium not to exceed 200% of your last policy premium.

CAREFULLY REVIEW YOUR POLICY REGARDING THE AVAILABLE EXTENDED REPORTING PERIOD COVERAGE, INCLUDING THE LENGTH OF COVERAGE, THE PRICE AND THE TIME PERIOD DURING WHICH YOU MUST PURCHASE OR ACCEPT ANY OFFER FOR EXTENDED REPORTING PERIOD COVERAGE.

Section 6 Severability

If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of such provision to other persons or circumstances shall not be affected thereby.

Section 7 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 8 Effective Date

This regulation is effective July 1, 2012.

Section 9 History

Originally issued as Regulation 86-4, effective November 1, 1986.

Re-codified as Regulation 5-1-8, effective June 1, 1992.

Amended, effective October 1, 1996.

Amended, effective September 1, 2003.

Amended Regulation 5-1-8 effective July 1, 2012.

Regulation 5-1-9 REGULATION TO REQUIRE REPORTING OF FINANCIAL AND STATISTICAL DATA BY PROPERTY AND CASUALTY INSURANCE COMPANIES

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § § 10-1-109, and 10-4-404(1), C.R.S.

Section 2 Purpose

The purpose of this regulation is to set forth the manner of reporting data by insurers to statistical agents, to prescribe reports to be submitted by statistical agents to the commissioner, and to prescribe certain conduct in connection therewith. This regulation does not apply to data reported directly by insurers to the commissioner.

Section 3 Applicability

This regulation applies to property and casualty insurers writing insurance in the State of Colorado. This regulation does not apply to title insurance, reinsurance and ocean marine insurance.

Section 4 Definitions

A. "NAIC Statistical Handbook or Handbook" is a publication of the National Association of Insurance Commissioners (NAIC) which explains insurance statistical data and contains reporting requirements and report formats to be regularly furnished by statistical agents.

B. "Statistical agent" is an entity that has been designated by the commissioner to collect statistics from insurers and provide reports developed from these statistics to the commissioner for the purpose of fulfilling the statistical reporting obligations of those insurers.

C. “Statistical plan” is a statistical agent’s system for collecting information from reporting insurers, including exposure, coverage, classification, territory, premium, loss and other information.

Section 5 Examination of Statistical Agents

To be designated to collect statistics from insurers for purposes of fulfilling the statistical reporting requirements of this rule, an entity other than a licensed advisory organization shall be subject to the same examination provisions as licensed advisory organizations.

Section 6 Filing of Statistical Plans by Statistical Agents

Every statistical agent shall file with the commissioner every statistical plan and every modification that it proposes to use to collect statistics to meet the requirements of this regulation.

Section 7 Statistical Plans and Reporting by Insurers

Every insurance company licensed in this state shall report its insurance statistical experience for lines of insurance covered by this regulation to a statistical agent designated by the commissioner. This data shall be submitted in accordance with statistical plans approved in accordance with Section 6 of this rule.

Section 8 Statistical Agents’ Compliance with Statistical Handbook

For every line of insurance wherein statistics are collected in this state, every statistical agent shall, at a minimum, collect statistics and file reports and compilations in the form and detail provided in the NAIC Statistical Handbook, 2004 edition, unless otherwise specified by the commissioner.

Section 9 Multiple Statistical Agents for the Same Line of Business

For lines of insurance where more than one statistical agent has been designated and collects statistics in this state, the statistical agents shall, if so directed by the commissioner, arrange to file combined reports for all statistical agents collecting data for the specified lines of insurance. The statistical agents may make arrangements among themselves for the equitable sharing of the costs to produce such combined reports.

Section 10 Edit and Control Procedures for Statistical Agents

Statistical agents shall adopt, edit and control procedures to screen and check data required by this regulation for reasonableness, accuracy and completeness. These procedures shall, at a minimum, conform to the specifications provided in the NAIC Statistical Handbook, 2004 edition, unless otherwise specified by the commissioner.

Section 11 Insurer Edit and Audit Procedures

Insurers shall adopt , edit and audit procedures to screen and check data required by this regulation to be reported to determine that such data meets the standards for reasonableness , accuracy , and completeness provided in the NAIC Statistical Handbook, 2004 edition, unless otherwise specified by the commissioner.

Section 12 Adoption of Changes to the Statistical Handbook

Revisions to the Statistical Handbook shall apply upon the commissioner’s notification to insurers or statistical agents of the adoption of the revisions and their effective dates. Statistical agents shall notify insurers that report to them of any changes that affect data collection or the reporting activities of insurers.

Section 13 Disclosure of Complying and Non-Complying Insurers

Statistical reports shall each contain a listing of insurers whose data are included. In addition, if data from an insurer or insurers that had agreed to have data included are, in fact, not included, then a listing of these insurers shall also be made with the statistical report as specified in the NAIC Statistical Handbook. For any insurer that is listed as not included in a statistical report, the statistical agent shall, upon the request of the commissioner, provide reasons for the exclusion.

Section 14 Access to Data

The commissioner shall have access to all statistical data that have been collected by statistical agents for the purpose of fulfilling the requirements of this regulation. Upon request by the commissioner, the statistical agent shall provide a copy of any report that it produces from data that the commissioner has required to be collected.

Section 15 Disclosure of Data

All data submitted to the Commissioner shall be considered public and shall be open to inspection by the public, unless the information may be considered confidential pursuant to § 24-72-204, C.R.S. If the statistical agent desires confidential treatment of any information submitted, as required in this regulation, a "Confidentiality Index" must be completed. The Division will evaluate the reasonableness of any request for confidentiality and will provide notice to the insurer or statistical agent if the request for confidentiality is rejected.

Section 16 Exemption

Upon application by a statistical agent or an individual insurer, the commissioner may allow the submission of a report or statistical data at a specified later date if the submission of the report or data on the date required by this regulation would create a substantial hardship on the statistical agent or insurer.

In considering whether to grant such an exemption, the commissioner shall consider whether the delay is necessitated by an unusual or a one-time situation, or whether the delay is necessitated by a situation that is likely to reoccur. When the delay is necessitated by a situation that is likely to reoccur, the commissioner may condition the granting of an exemption on whether the insurer or statistical agent has a plan of action to address the situation in the future.

Section 17 Lines of Insurance without a Statistical Agent

Any licensed insurer writing any line of insurance not exempted in Section 3 of this regulation that finds or believes to have found that it is writing a line or type of insurance for which no statistical agent will accept data shall notify the commissioner of this fact as soon as practicable.

Section 18 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 19 Incorporated Materials

The NAIC Statistical Handbook or Handbook published by National Association of Insurance Commissioners shall mean the Handbook as published on the effective date of this regulation and does not include later amendments to or editions of the Handbook. A copy of the Handbook may be examined at any state publications depository library.

Section 21 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 22 Effective Date

This regulation shall become effective on August 1, 2012.

Section 23 History

Original regulation effective May 1, 1988.

Repromulgated regulation effective August 1, 2012.

Regulation 5-1-10 RATE AND RULE FILING SUBMISSION REQUIREMENTS PROPERTY AND CASUALTY INSURANCE

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § § 10-1-109, 10-3-1110, 10-4-110.7, 10-4-404, 10-4-404.5, and 10-11-118 C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to ensure that property and casualty insurance rates are not excessive, inadequate or unfairly discriminatory by establishing the requirements for rate and rule filings. This regulation contains annual rate filing requirements for homeowners and private passenger automobile insurance. These lines of business are specifically included in this regulation because these products are widely purchased by consumers. Annual rate filings, rather than other methods the Division of Insurance (Division) may use, are preferred because of the prospective nature of the information contained in rate filings. Since a company's rates filed with the Division must be used until replaced by another rate filing, the Commissioner of Insurance cannot determine if rates included in prior rate filings continue to be appropriate for current or future economic conditions, or adequately reflect recent Colorado loss experience. Rate filings are reasonable and necessary means to ensure that current rates are appropriate and compliant with Colorado statutes and regulations.

Section 3 Applicability

This regulation applies to all rate filings submitted by companies operating in the state of Colorado as defined in Section 4. The following lines of business, however, are specifically excluded from the requirements of this regulation: reinsurance, ocean marine, life, health, surplus lines, insurers negotiating and entering into insurance coverage agreements with an exempt commercial policyholder and credit insurance subject to the requirements of Colorado Insurance Regulation 4-9-2.

Section 4 Definitions

A. “Classification System" or "Classification" means the plan, system, or arrangement for recognizing differences in exposure.

B. “Company” means all licensed property and casualty insurance companies, including an entity created pursuant to § § 8-45-101 and 8-45-117, C.R.S. It does not include captive insurance companies licensed under Article 6 of Title 10 or self-insurance pools licensed under Article 44 of Title 8, Section 115.5 of Article 10 of Title 24, or Section 102 of Article 13 of Title 29.

C. “Exempt Commercial Policyholder” shall have the same meaning as defined in Colorado Regulation 5-1-13, 4, C.

D. “Expense Multiplier” means the portion of the rate that includes provisions for expenses, other than loss adjustment expenses, profit and investment income.

E. “On-Rate Level Premium” is the premium that would have been generated if the present rates had been in effect during the entire period under consideration.

F. "Premium" means the amount of money charged a policyholder for an insurance policy.

G. "Prior Approval" is a filing procedure that requires a rate, rule, or loss cost change to be affirmatively approved by the Commissioner prior to distribution, release to producers, collection of premium, advertising, or any other use of the rate, rule, or loss cost.

H. “Qualified Actuary” is a person who meets the requirements of Colorado Insurance Regulation 1-1-1.

I. "Rate" means the cost of insurance per exposure unit. Rates must include an adjustment to account for expenses, profit, and variations in loss experience, but are prior to any application of individual risk variations based on loss or expense considerations.

J. "Rating Manual" means the rates, schedule of rates, rating plans, rating classifications, territories, rating rules, and any other information which the company uses to determine the final dollar charge for insurance coverage.

K. “Trend” or “Trending” means any procedure for projecting losses to the average date of loss, or of projecting premium or exposures to the average date of writing.

Section 5 Rules

All rate, rule, and loss cost filings shall be submitted electronically by licensed companies, rating organizations and advisory organizations (except for conditions provided by regulation). Failure to supply the information required in Subsections 5(A)(4), 5(A)(5), 5(A)(7), and 5(B)(4) of this regulation would render the filing incomplete. Incomplete filings will be rejected on or before the 15th business day after receipt. Incomplete filings are not reviewed for substantive content. All filings that are not returned on or before the 15th day after receipt will be considered complete. Filings may be reviewed for substantive content, and if reviewed, any deficiency will be identified and communicated to the filing insurer on or

before the 30th business day after receipt. Correction of any deficiency, after the 30th business day, will be required on a prospective basis, and no penalty will be applied to a non willful violation identified in this manner. Nothing in this Section 5 shall render a rate filing subject to prior approval by the Division unless otherwise subject to prior approval as provided by statute.

A. Rate Filings General Requirements

1. Required Submissions:

   a. All companies must submit rate filings whenever the rates charged to new or renewal policyholders differ from the rates on file with the Division. Included in this requirement are changes due to periodic recalculation of experience or projections, change in rate calculation methodology, or change(s) in trend or other rating assumptions.

   b. Annual rate filings for homeowners insurance and private passenger automobile insurance – All foreign companies with written premiums for homeowners insurance (line 4 from the Colorado exhibit of premiums and losses from the annual statement) or private passenger automobile insurance (the sum of lines 19.1, 19.2, and 21.1 from the Colorado exhibit of premiums and losses from the annual statement) in excess of $10,000,000 in the preceding calendar year, and all Colorado domestic companies without regard to annual written premium, must submit a homeowners and/or private passenger automobile rate filing on at least an annual basis. Each rate filing must be submitted to the Division on or before the one-year anniversary of the filing date of the most recent rate filing made by a particular company for that line of business. “Annual rate filing” shall contain all of the items required in this regulation and the bulletin entitled, “Requirements for the Filing of Rates, Rules, Loss Cost, and Forms for Property and Casualty Carriers." The rate filing must demonstrate that the rate the company is using or proposing to use is not excessive, inadequate or unfairly discriminatory.

   c. These rate filings shall be considered “file-and-use” and treated in the same manner as rate filings from other Type II insurance lines.

   d. All rate filings required by this regulation must contain detailed support demonstrating that the assumptions continue to be appropriate, and that rates are not excessive, inadequate or unfairly discriminatory.

2. Timing and Submission: Unless a filing is specifically identified as requiring prior approval, by statute, all filings are classified as file-and-use. All companies are to file appropriate Colorado Rate and Rule Submission Form(s) (Form A is required for all filings and loss cost filings require a form B, C and/or D, as appropriate) with the rates prior to distribution, release to producers, collection of premium, advertising, or any other use of the rate. Additionally, all personal lines, medical malpractice, commercial lines, and workers compensation insurance require the rating data to be submitted with the filing. The Division may also request rating data for other lines of business along with appropriate supporting data. All filings must be submitted to the rates and forms section of the Division. In the case of rates requiring prior approval, if a rate increase has been implemented without Division approval, corrective actions may be ordered, including fines, refunds to policyholders, and/or rate credits.

3. Withdrawn or Returned Filings: Filings that have either been withdrawn by the filer or returned by the Division as incomplete, and subsequently resubmitted, will be considered new filings and must have a new filing date and effective date (new effective date if the date has expired). If a filing is withdrawn or returned, the rates may not be used or distributed.

4. Submission of rates, rules, and loss cost filings: All filings must be submitted electronically in a format made available by the Division. These filings must be submitted, by company, so that each filing contains all required documents. Required documents include (at a minimum) the cover letter and filing forms A, B, C and D, if appropriate. If the company fails to comply with these requirements, then the company will be notified that the filing has been rejected as incomplete. If a filing is rejected due to lack of completeness, then the rates may not be used or distributed.

5. Group Filings: Group filings are allowed to be submitted in one filing for multiple companies in the same holding group as long as company-specific information, forms, support, data, manuals, and all other required information is provided. Group data and support are acceptable in addition to company specific data to support the rates so long as the source of the experience is clearly identified.

6. Required Inclusions: The level of detail and the degree of consistency incorporated in the experience records of the company are vital factors in the presentation and review of rate filings. Every personal lines, commercial lines, medical malpractice, title, and workers compensation rate filing shall be accompanied by sufficient information to support the reasonableness of the rate. Valid company experience should be used whenever possible. This information may include the company's experience and judgment; the experience or data of other insurers or organizations relied on by the company; the interpretation of any statistical data relied on by the company; descriptions of methods used in making the rates; and any other similar information. In addition, the Commissioner may request any information necessary to adequately support the rate request.

7. Each rate filing must include:

    a. Required Forms: A fully completed Rate and Rule Filing Submission Form A and loss cost filing forms B, C and/or D (when appropriate) are required. These forms are available from the Division and are contained in a separately published bulletin.

    b. Summary: The filing must include a brief written summary of the reason for the rate filing; the methodology used to develop the rate change; marketing method; premium classes; product description; and any relevant considerations which have a material effect upon the ratemaking methodology.

    c. Territorial Factors: The initial personal lines, medical malpractice, commercial lines, and workers compensation insurance filings must clearly display and adequately support all territorial factors and definitions, and any subsequent personal lines, medical malpractice, commercial lines and workers compensation insurance filings must clearly display and adequately support all changes in territorial factors and definitions.

    d. Side-by-Side Comparison: A "side-by-side comparison" including the proposed change(s) must be included in the filing. The "side-by-side comparison" should include three columns: the first containing the current rates, rating factor, rating variable, or rules; the second containing the proposed rates, rating factor, rating variable, or rules; and the third containing the percentage increase or decrease of each proposed change(s). If the proposed rates are not replacing existing rates, then the filing must specifically so state.

    e. Loss Offsets: For all lines of business for which the ultimate loss payments are expected to be affected by the subsequent collection of salvage or subrogation amounts, or through the coordination of benefits, such anticipated reductions must be considered, either implicitly or explicitly, in the rate making process.

f. Loss Ratios: The filing must state the anticipated loss ratio for the period the rates are projected to be applicable. This should be stated on an incurred basis as the ratio of incurred losses to earned premiums. Incurred losses may include loss adjustment expenses, but the filing must clearly identify the components of the loss ratio. The anticipated loss ratio shall be submitted on all rate and loss cost filings, with all the necessary support to show how the loss ratio was developed.

g. Rate History: The filing must include a chart showing the rate changes implemented in at least the three years immediately prior to the date of the filing.

h. Data Requirements: The personal lines, medical malpractice, commercial lines and workers compensation filing must, at a minimum, include past and prospective loss experience, loss costs or pure premium rates, and premiums. The Division may also request rating data for other lines of business along with appropriate supporting data for any line of business. This information shall be submitted on a Colorado-only basis for at least three years, if available, and on a national, regional or other appropriate basis if the Colorado data is not fully credible. The loss data must be on an incurred basis including both the accrued and unaccrued portions of the liability and reserve (e.g., case, bulk and IBNR reserves) as of the valuation date. Premiums and/or exposure data must be stated on both an actual and on-rate level basis.

i. Development of expected loss or pure premium: The personal lines, medical malpractice, commercial lines and workers compensation filing must adequately support all material assumptions and methodologies used to develop the expected losses or pure premiums. Material assumptions and methodologies may include but are not necessarily limited to:

(1) Catastrophic losses: The filing must clearly identify the degree to which the underlying data was adjusted for catastrophic or large losses and must describe the method (if any) used to prospectively provide for catastrophic losses.

(2) Trend: The filing must discuss and adequately support any trends or trending assumptions (whether applied to loss, premium or exposure data) that are used.

(3) Credibility: The filing must discuss the credibility of the data, and the source, applicability, and use of collateral data.

(4) Investment Income: The filing must describe how anticipated investment income will be used to reduce the prospective rate.

(5) Exposure base: If the exposure base to which the rate is applied is subject to inflationary or other trend, then the filing must either demonstrate that the loss trend has made due consideration for the offsetting exposure trend, or that the changing exposure trend has been adequately taken into account in the development of the prospective rates.

j. Expense Provision: The personal lines, medical malpractice, commercial lines, title, and workers compensation filing must clearly describe the amount of the fixed and/or variable expense provision and how this provision is to be accounted for in the final rate. This justification must include a statement that the expense provision has been adjusted to appropriately reflect Colorado requirements and reflects the operating methods of the company and any Colorado-specific

anticipated expenses. Specifically, the provision for taxes, licenses and fees varies according to the jurisdiction and according to the existence of a regional or home office which qualifies as a Home or Regional Home Office under Colorado Insurance Regulation 2-1-2 and § 10-3-209(b)(I)(B), C.R.S. The expense provision in the filing must accurately reflect any such Colorado-specific expense.

k. Provision for Profit and Contingencies: The personal lines, medical malpractice, commercial lines, title, and workers compensation filing must identify the amount or percentage of the provision for profit and contingencies and how this provision is added to the final rate. Investment income shall be considered from unearned premium reserves, reserves from incurred losses, and reserves from incurred but not reported (IBNR) losses.

B. Additional Rate Filing Requirements by Line

The following subsections set forth the requirements by separate lines of insurance that must be complied with in addition to the above general requirements.

1. Type I Lines: Type I filings are defined in § 10-4-401, C.R.S. All filings for Type I lines of insurance require prior approval.

2. Rate Modification Plans: Rate modification plans are rating plans or procedures which provide a listing of various risk characteristics or conditions and a range of modification factors which may be applied for these characteristics or conditions to the manual rate of a particular insurance risk. Rate modification plans are regulated by Colorado Insurance Regulation 5-1-11. All requirements of Colorado Insurance Regulation 5-1-11 should be observed, in addition to the requirements of this regulation, whenever a rate modification plan is filed.

3. Adoption of Advisory or Rating Organization Rates: Each company adopting pure premium rates must file their final loss cost multiplier. If the company requests that its final loss cost multiplier which includes the pure premium rate modification remains on file without change, it will remain in effect until the company withdraws it, files revised pure premium rate adjustments, files expense adjustments, or makes an independent filing. However, any company that delays, modifies, or fails to adopt a subsequent filing made by the rating or advisory organization must promptly make an appropriate filing with the Division.

If the rating or advisory organization prints and distributes the pure premium rates, any company that adopts those pure premiums with or without modification is not required to file its final rate pages with the Division, even if the company chooses to print and distribute final rate pages based solely upon the application of its filed final loss cost multiplier for its own use. If the rating or advisory organization does not print the pure premium rates in its manual, then the company must submit its final rates to the Division.

The final loss cost multiplier must include a provision for expenses (expense multiplier) and may include an adjustment to the pure premium rate (pure premium rate modification). The final loss cost multiplier is a combination of these two adjustments:

a. Expense Multiplier:

(1) The required expense multiplier must provide for the company's actual production expense, general expense, profit and contingencies with the investment income offset provisions, taxes, licenses and fees, and any other necessary expense. The description of the expense components must be made on the appropriate filing form. Companies that adopt

advisory pure premium rates may vary the expense provision by individual classification, grouping, or subline of insurance only to the extent that the actual expenses of the company do in fact differ by these separate classifications, groupings or sublines. Companies may use variable and/or fixed expense provisions to establish the appropriate expense provision in the final loss cost multiplier.

(2) The expense multiplier shall make provision only for expenses. No implicit or explicit provision for actual or anticipated differences in the pure premium rate may be included in the development of the expense multiplier.

b. Pure Premium Rate Modifications: A company may file for modification of the pure premium rates based on its own anticipated experience. This modification must be made on the appropriate filing form. Supporting actuarial or statistical documentation is required to adequately support the reasonableness of any modifications of the advisory pure premium rate.

4. Medical Malpractice:

As required by § 10-4-403(2.1), C.R.S., medical malpractice filings shall include an analysis and opinion of a qualified actuary. The analysis and opinion must discuss the impact, if any, of the following on the rates:

a. Tort reform legislation.

b. Risk management activities.

c. Underwriting standards and practices.

d. Any other activity designed to reduce rates or rate increases or the cost of administration and determination of claims.

The qualified actuary must state an opinion as to whether the rates are excessive, inadequate or unfairly discriminatory.

5. Title Insurance:

a. Licensed title insurance companies: As required by § 10-11-118 C.R.S., shall submit a complying filing electronically including justification for any new or amended rate or fee and an effective date that is at least thirty (30) days after the date the Division receives the filing electronically. The justification for the new or amended rate or fee shall include but not be limited to:

(1) The expense provisions and demonstrate how these provisions are accounted for in the final rate or fee;

(2) Expected ultimate losses and loss adjustment expenses (LAE), and LAE ratios.

(3) Rate history listing the effective date and amount of any rate or fee changes made in the past three (3) years; and

(4) Methodologies and material assumptions in developing the rate or fee;

(5) The amount and description of all profit and contingencies built into the rate or fee; and

(6) Any other determining factor used to develop the final rate or fee.

b. Title agencies: As required by §10-11-118 C.R.S., shall submit a complying filing directly to the Division including justification for any new or amended fee with an effective date that is at least thirty (30) days after the date the Division receives the filing. The justification for the new or amended fee shall include but not be limited to:

(1) The expense provisions and demonstrate how these provisions are accounted for in the filing;

(2) Actual expenses associated with the fee;

(3) The amount and description of all profit and contingencies built into the fee; and

(4) Any other determining factor used to develop the final fee.

6. Homeowners:

As required by § 10-4-110.7(4), C.R.S., homeowners filings containing underwriting methodologies are not public record. Any homeowner's filing containing information that a company considers to be an underwriting methodology must clearly identify this information as confidential, complete the proper confidentiality request, and segregate it from the rest of the filing so that the Division is able to properly maintain confidentiality.

C. Rule Filing General Requirements

1. Required Forms: A fully completed Filing Form A is required. Filing forms are available from the Division and are contained in a separately published bulletin or the SERFF website and may be duplicated by insurers.

2. Every property and casualty insurance company, including those writing workers' compensation and title insurance, is required by this regulation to provide a list of minimum premiums, schedule of rates, rating plans, dividend plans, individual risk modification plans, deductible plans, rating classifications, territories, rating rules, rate manuals and every modification of any of the foregoing which it proposes to use. Such filings must state the proposed effective date thereof, and indicate the character and extent of the coverage contemplated.

3. Companies may adopt, by reference, rating and/or advisory organization insurance rating plans, individual risk modification plans, deductible plans, rating classifications, territories, rating rules, rate manuals, and modifications of any of the foregoing. A completed copy of the appropriate filing form prescribed by the Commissioner in a separate bulletin must accompany the filing.

4. Each rule filing must identify the kind of insurance, (e.g., Type II), and must be consistent with the rate filing procedure defined for that type of insurance. Each filing must be accompanied by a completed copy of the appropriate filing form prescribed by the Commissioner in a separate bulletin.

5. Each rule filing must include a side-by-side comparison of any change proposed. If the proposed rules are not replacing existing rules used by the filer, then the filer must so state in the filing.

D. Prohibited Practices

The Division has determined that certain rating practices lead to excessive, inadequate or unfairly discriminatory rates and are unfair methods of competition and/or unfair or deceptive acts or practices in the business of insurance. Therefore, in accordance with § 10-3-1110(1), C.R.S., it is considered an unfairly discriminatory practice for a company to include, in any component of a rate, any amount intended to recover losses or expenses incurred in another state or jurisdiction due to any referendum, law or regulation which requires a general reduction in rates. This subsection shall not prohibit the use of national, regional or other industry data as a necessary and actuarially supportable supplement to Colorado data that is not fully credible.

Section 6 Severability

If any provision of this regulation or the application thereof to any person or circumstances is for any reason held to be invalid, the remainder of the regulation and the application for such provision to other persons or circumstances shall not be affected thereby.

Section 7 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 8 Effective date

This regulation is effective October 1, 2012.

Section 9 History

Regulation 91-1, effective March 1, 1991.

Re-codified as Regulation 5-1-10 on June 1, 1992.

Regulation repealed and re-promulgated, effective February 1, 1999.

Amended regulation, effective January 1, 2000.

Amended regulation, effective March 2, 2002.

Amended regulation, effective August 1, 2009.

Amended regulation, effective October 1, 2012.

Regulation 5-1-11 RISK MODIFICATION PLANS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § § 10-1-109, 10-4-401, 10-4-403, 10-4-404, and 10-4-408, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to provide criteria for the modification of commercial property and casualty manual rates and to establish workers' compensation disclosure requirements.

Section 3 Applicability

This regulation applies to all insurers writing commercial property and casualty insurance policies, including workers' compensation insurers, licensed to conduct business in this state and Pinnacol Assurance.

Section 4 Definitions

A. "Anniversary date" means the annual anniversary of the date of issue of a policy as shown in the policy declaration.

B. "Certified workers' compensation risk management program" means a program which meets the minimum standards outlined in Colorado Insurance Regulation 5-3-1 and is certified with a Cost Containment Certificate by the Colorado Cost Containment Board.

C. "Designated medical provider" means any physician, hospital, clinic or physician of a preferred provider organization network who meets all of the qualifications of a designated medical provider outlined in Regulation 5-3-1, which defines minimum risk management standards for cost containment certification.

D. "Experience rating plan" means any rating plan or system wherein a manual rate for insurance is adjusted or modified based on the past loss experience of the insured.

E. "Improved workers' compensation loss experience for experience or schedule rated insured business entities" means lower frequency and severity of losses for the last policy period as compared with frequency and severity of losses within the immediate prior policy period. If loss experience is not available for the complete last policy year, losses must be compared for equal periods of time (eight months vs. eight months, ten months vs. ten months, etc.). Whether the risk management program certification credit applies and whether the business entity's loss experience has improved shall be determined by the insurer prior to granting the cost containment credit. The Colorado Cost Containment Board reviews the business entity's loss record for the purpose of certification of the risk management program only.

F. "Initial certification date" means the date the risk management program of a business entity is initially certified by the Colorado Cost Containment Board. A risk management program that meets the risk management standards of Colorado Insurance Regulation 5-3-1 shall be initially certified one year after the implementation of the program by the business entity.

G. "Initial effective date of the premium dividend resulting from the implementation of a risk management program" means the annual anniversary date of a workers' compensation policy immediately after the risk management program has been certified by the Colorado Cost Containment Board. If the annual anniversary date is within thirty (30) days of the date a risk has been certified, a grace period for the application of a premium dividend is allowed. However, a grace period, when allowed, must be applied consistently.

H. "Manual rate" means a rate designed to apply on a generic basis to similar risks within the same class, filed by an insurer or rating/advisory organization with the Division of Insurance and made part of the rating manual used by an insurer or rating/advisory organization.

I. "Payroll" means the remuneration paid or payable by the business entity for services of employees. Remuneration is money or substitutes for money including commissions, bonuses, extra pay for overtime, pay for vacations, holidays and sickness, statutory insurance or pension plans, payments for piece work, allowances for tools, the rental value of an apartment, and the value of lodging and meals.

J. "Premium Differential" means an adjustment to the workers' compensation premium when the insured business entity has selected a designated medical provider.

K. "Premium dividend resulting from the implementation of a risk management program" means the credits allowed for business entities which implement a risk management program and comply with the standards established by Colorado Insurance Regulation 5-3-1 and the business entity's loss experience under the risk management program indicates that such premium dividend is warranted.

L. "Premium dividend resulting from rehiring previously injured employees" means the credit arrived at for employers who rehire previously injured employees who sustained permanent partial disabilities.

M. "Rate modification plan" (commonly called Schedule Rating Plan or Individual Risk Premium Modification Plan) means a rating plan or procedure which provides a listing of various risk characteristics or conditions and a range of modification factors which may be applied for these characteristics or conditions to the manual rate of a particular insurance risk. The effect of the modification factor is to increase (debit) or decrease (credit) the manual rate. Rate modification plans exclude merit rating plans and retrospective rating plans.

N. "Rehired employee with permanent partial disabilities" means an employee who sustained permanent partial disabilities and is reemployed by the same employer, not a successor, at the pre-injury wages including any wage increases to which such employee would have been entitled had the employee not been injured.

O. "Renewal date of premium dividend" means each annual anniversary date of a workers' compensation insurance policy after the initial effective date of the premium dividend.

Section 5 Rules

A. Rate Modification Plans

Rate modification plans, justified according to the standards herein, are permitted. However, the commissioner has determined that the use of unjustified rate modification plans is not reasonable, is not objective and is unfairly discriminatory. Therefore, the use of unjustified rate modification plans in rating of commercial property and casualty insurance risks located in Colorado is prohibited.

The following elements shall be considered in determining whether or not a rate modification plan, or its use, is justified:

1. Rate modification plans must be used to acknowledge variance in risk characteristics and not merely to gain competitive advantage.

2. Rate modification plans must be based only on rating characteristics not already reflected in the manual rates. The plans must clearly indicate the objective criteria to be used.

3. If a risk is experience rated, the amount of the credit or debit derived from using a rate modification plan (Schedule Rating Plan) shall be applied to an experience rated risk in a

multiplicative manner, after application of the experience modification, and before the application of the cost containment dividend, premium discounts and expense constants.

4. Individual underwriting files must contain the specific criteria and document the particular circumstances of the risk that support each debit or credit. This documentation must exist in the underwriting file or credible electronic record to enable the commissioner to verify compliance with this regulation. Documentation may include, but is not limited to, inspection reports, photographs, agent observations and findings, insured's formal safety plans, premises evaluations, and narrative reports covering other aspects of the risk. For the purpose of workers' compensation insurance, documentation must include a copy of the employer's Colorado Cost Containment Certificate if a premium dividend is allowed. Misclassification of a risk will be considered a modification without justification.

5. Any rate modification plan designed to be applied simultaneously to property, liability, or vehicle coverage shall contain reasonable factors that give appropriate recognition to the distinct exposures involved in such coverages.

6. Once an insurer has filed a rate modification plan, its use is mandatory. Insurers may use judgment in selecting the amount of credit or debit stated within a range of credits or debits. However, such credits or debits must be applied uniformly in a nondiscriminatory manner for all eligible classes of risks eligible under a rate modification plan, even if the application of the plan results in a zero modification, or no change in a previous modification applied.

7. The application of any rate modification plan shall not result in debits or credits that exceed 25%. The rate modification plan must state specifically the 25% maximum limitation. Modifications generated by experience (experience rating) or company expense experience (company deviation plans) are not subject to the 25% limitation. Company deviation plans may be applied in addition to experience modifications, rate modifications and premium discounts.

8. Once a rate modification plan has been applied to a risk and a credit or debit established, no change in the established credit or debit can be made without appropriate justification and documentation. If such justification and documentation becomes available during the policy period, the established credit or debit cannot be changed until the next anniversary date of the insurance policy.

9. A rate modification plan shall not apply to minimum premium policies.

10. Any rate modification plan must provide that when a risk is rated below average (debited), an insured or applicant, upon request, will be advised by the insurer of the factors which resulted in the adverse rating so that the insured or applicant will be fairly apprised of any corrective action that might be appropriate with respect to the insurance risk.

B. Experience Rating Plans

Experience rating plans shall be calculated from at least three complete years of premium or payroll and loss data, except if a lesser time period has been approved by the Commissioner. Experience rating plans cannot be calculated with estimated premiums or payroll. Premium or payroll and loss figures used in the calculation must be verifiable and justifiable.

C. Workers' Compensation Cost Containment Certification and Selection of Designated Medical Provider disclosure

All workers' compensation insurers, including Pinnacol Assurance, shall disclose the availability of cost containment certification by the Colorado Workers' Compensation Cost Containment Board and the potential premium savings on the face of the insurance policy or in a separate disclosure form attached as an addendum to the policy. Such disclosure applies regardless of whether or not a risk is experience or schedule rated. Insurers shall require that the insured business entity indicate on a form developed by the insurer, that the business entity is aware of the possible premium dividend if the business entity's risk management program is certified by the Colorado Cost Containment Board. This form shall be made part of the insured business entity's underwriting file.

On an annual basis, all workers' compensation insurers, including Pinnacol Assurance, shall disclose the premium differential on the face of the insurance policy or in a separate disclosure form attached as an addendum to the policy when the policyholder has selected a designated medical provider. Such disclosure applies regardless of whether a risk is schedule rated. Insurers shall require that the insured business entity indicate, on a form developed by the insurer, that the business entity is aware of the premium differential for selecting a designated medical provider. This form shall be made part of the insured business entity's underwriting file.

D. Premium Dividend for Certified Risk Management Programs

Insured Business Entities Qualifying for Experience and/or Schedule Rating: If an insured business entity qualifies for experience and/or schedule rating under its workers' compensation insurance and the insured business entity has implemented a certified workers' compensation risk management program, the insurer must allow a 5% premium dividend if the loss experience has improved since the last renewal date of workers' compensation insurance. The premium dividend shall be in addition to the maximum schedule rating deviation of 25%. The schedule rating and cost containment discounts shall be applied multiplicatively. Therefore, the maximum schedule rating credit (0.75) multiplied by the cost containment certification premium dividend (0.95) cannot exceed 28.75%.

Insured Business Entities Not Qualifying for Experience and/or Schedule Rating: If an insured business entity does not qualify for experience and/or schedule rating under its workers' compensation insurance and the insured business entity has implemented a certified workers' compensation risk management program, the insurer must allow the following premium dividend:

Premium Dividend	Dividend Criteria
10%	If the insured business entity has been loss free for at least the last year immediately preceding the effective date of the premium dividend.
8%	If the insured business entity had one medical loss exceeding $250 in the last year immediately preceding the effective date of the premium dividend.
6%	If the insured business entity had two medical losses, each exceeding $250, in the last year immediately preceding the effective date of the premium dividend.
4%	If the insured business entity had three medical losses, each exceeding $250, in the last year immediately preceding the effective date of the premium dividend.
2%	If the insured business entity had three medical losses, each exceeding $250, and one claim for loss of time in the last year immediately preceding

	the effective date of the premium dividend.
0%	If the insured business entity had more than three medical losses and one claim for loss of time in the last year immediately preceding the effective date of the premium dividend.

The application of the premium dividend up to 10% shall be dependent on available loss statistics on the initial and the renewal date of premium dividends. However, if loss statistics are not available at the initial or renewal date of the premium dividend, such loss statistics shall be applied on the subsequent renewal date. If an insured business entity changes insurers, the replaced insurer must furnish such loss statistics to the business entity prior to the effective date of the new policy.

Individual underwriting files must contain a copy or electronic record of the insured business entity's Colorado Cost Containment Certificate and historical and current loss statistics, or credible evidence available from the Colorado Division of Workers' Compensation that such entity qualifies and has received cost containment certification.

Any other rating plan which incorporates the characteristics of the plan for "premium dividend" as defined in this regulation, may be substituted for the plan for premium dividend. However, under no circumstance, can such a substitute rating plan allow for credits already reflected in the rates.

E. Premium Differential for Selection of Designated Medical Provider

All workers' compensation insurers, including Pinnacol Assurance, must allow a credit of 2.5% as a premium differential of the workers' compensation insurance premium if the insured business entity has selected a designated medical provider. If an insured business entity is eligible for schedule rating, the 2.5% credit must be included in the total schedule credit or debit, subject to the 25% maximum limitation.

Whenever the insurer allows the premium differential in the schedule rating for an insured business entity which selects the designated medical provider, the insurer must report the premium differential, separately, to the rating/advisory organization to capture this information.

If an insured business entity is not eligible for experience or schedule rating, the 2.5% credit shall be applied in addition to the premium divided applicable. The combined premium dividend and the 2.5% credit for selection of a designated medical provider shall not exceed 12.5%.

F. Workers' Compensation Premium Dividend for Employing Previously Injured Employees with Permanent Partial Disabilities

The workers' compensation premium dividend applies to all workers' compensation policies with large or small premiums, except policies subject to minimum premiums. The dividend shall be calculated annually after a policy has expired and shall apply to the premium developed from the payroll of the rehired injured employees who sustained permanent partial disabilities (payroll of rehired employees x manual rates x ratio of rehired employees with permanent partial disabilities to injured employees with permanent partial disabilities). This premium shall be subject to all risk modification credits or debits otherwise applicable under the policy. If any employee is rehired during a policy period or was not rehired for the total policy term, the rehired employee shall be considered as being rehired for the total annual policy period or term. The workers' compensation premium dividend applies to all policies which expire on or after March 1, 1993 and all renewal policies thereafter as long as an injured employee who sustained permanent partial disabilities

remains with the same employer. In calculating the premium dividend, insurers shall use the following formula:

(R / I) (P) = D

If (R / I) is greater than 10%, (R / I) = 10%

Assumptions:

R = The number of injured employees with permanent partial disabilities who were rehired during a given policy period.

I = The number of injured employees who sustained permanent partial disabilities during the same given policy period.

P = The actual payroll of reemployed injured employees who sustained permanent partial disabilities multiplied by the manual rate for the classification of the reemployed injured employees. If employees fall into different manual rate classifications, payroll of each employee should be multiplied by the appropriate manual rate. The sum of these would equal P.

D = Amount of premium dividend subject to a maximum of 10% annually.

The premium dividend shall be adjusted annually based on the number of injured employees who sustained permanent partial disabilities rehired within the given policy period.

G. Reporting of Pertinent Information

Upon the request of the commissioner, an insurer to which this regulation applies, shall submit data to the commissioner establishing the relationship of the aggregate premiums actually charged policyholders by the insurer for each line of commercial insurance to the aggregate premium that would have been produced by the insurer's filed unmodified rates for that line of commercial insurance. A rating/advisory organization may file the data on behalf of the insurer.

H. Rate Compliance Examinations

To determine compliance with this regulation the commissioner may order a compliance examination be made of any insurer to which this regulation applies.

I. Filing of Rate Modification Plans

Each insurer to which this regulation applies, shall file its rate modification plan (Schedule Rating Plan), its plan for premium dividend or its substitute plan, and the premium differential for the selection of a designated medical provider prior to implementation with the Division of Insurance.

Section 6 Severability

If any provisions of this regulation or its application to any person or circumstances are for any reason held to be invalid, the remainder of the regulation shall not be affected in any way.

Section 7 Enforcement

Noncompliance with this Regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of fines, issuance of cease and desist orders, and/or suspensions or revocation of insurance licenses.

Section 8 Effective Date

This amended regulation is effective on June 1, 2012.

Section 9 History

New regulation 88-3, effective 1988

Amended regulation 91-4, effective May 1, 1991.

Re-codified as regulation 5-1-11, effective January 1, 1992.

Amended as regulation 5-1-11, effective March 1, 1993.

Amended as regulation 5-1-11, effective April 1, 1997.

Amended as regulation 5-1-11, effective May 1, 2003.

Amended regulation effective June 1, 2012.

Regulation 5-1-12 CONCERNING WARRANTIES AND SERVICE CONTRACTS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § § 10-1-108(8) and 10-1-109, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish a distinction between a written agreement that is an insurance contract pursuant to § 10-1-102(12), C.R.S. and a written agreement that meets the definition of a written warranty or service contract and is not subject to regulation by the Division of Insurance (Division).

The Division has received numerous inquiries regarding contracts which may be insurance and are sold as warranties or service contracts. The definitions and rules contained herein set forth certain conditions which will cause a contract to be considered a contract of insurance, and thereby regulated by the

Division, and warranty contracts and service contracts which may not be regulated unless specifically addressed in the Colorado statutes, rules and regulations.

Section 3 Applicability

This regulation applies to written agreements in which services are promised to be rendered or the purchaser of property, personal or real, is guaranteed repair, replacement or indemnification for such repair or replacement of the property on the discovery of defects, loss, or damage to the property during a specified or unlimited period of time after purchase.

This regulation applies to written agreements which provide a benefit including but not limited to, prepaid legal, accounting, or other services.

This regulation shall not apply to contracts issued as warranties and/or service contracts regulated by § § 42-10-103, et. seq., 42-11-101, et. seq. and 12-61-602, et. seq., C.R.S.

This regulation shall not apply to written agreements providing health benefits or health service plans.

Section 4 Definitions

For the purposes of this regulation:

A. "Closed panel" means an individual or a group of providers which are linked by ownership or contract arrangements to the issuer of the contracts.

B. "Contract" means a written agreement for consideration.

C. "Indemnify" means to make compensation for damage, loss, or injury suffered.

D. "Service contract" means a contract whereby specified or designated services are obligated to be performed over a fixed period of time or for a specified duration.

E. "Supplier" means the manufacturer, wholesaler or retailer of a product or thing being sold and warranted or guaranteed.

F. "Written warranty" means

1. Any written affirmation of fact or written promise made in connection with a sale of real or personal property by a supplier to a buyer which relates to the nature of the material or workmanship and affirms or promises that such material or workmanship is defect free or will meet a specified level of performance over a specified period of time, or

2. Any undertaking in writing in connection with the sale of real or personal property by a supplier to refund, repair, replace, or take other remedial action with respect to such product in the event that such property fails to meet the specifications set forth in the undertaking, which written affirmation, promise, or undertaking becomes part of the basis of the bargain between a supplier and a buyer for purposes other than resale of such product.

Section 5 Rule

A service contract will not be a contract of insurance if the issuer has the ability to and provides the services or meets the following conditions:

A. Has a closed panel of providers who agree to provide all the services promised to any contract holder of the plan;

B. The closed panel must be responsible for providing services whether or not the issuer, which collects the dues and pays the providers, becomes bankrupt or otherwise ceases to function in the anticipated manner;

C. The closed panel of providers must have a factual and realistic capability to provide all the services obligated to the contract holder; and

D. There must be no indemnification contracted for by either the administrative unit or the providers of the plan for services or risk contingencies performed by any other entity outside the closed panel.

The issuer of these contracts may be the supplier, an individual, entity or association. Associations may issue service contracts only if the association is solely comprised of members who will provide the services.

A written agreement issued by the supplier of a product which meets the definition of a written warranty under this regulation is not a contract of insurance. Any other person who issues a written warranty, promise or contract to a product buyer for consideration is engaged in the business of insurance.

A contract which agrees or promises to indemnify the purchaser directly or promises to indemnify others for providing such agreed upon services and meets the definition of insurance as set forth in § 10-1-102(12), C.R.S., is a contract of insurance.

If a written agreement is such that any part of the agreement is considered to be a contract of insurance, then the entire agreement shall be considered to be a contract of insurance.

A written agreement which would otherwise be considered a contract of insurance with the exception of not having charged an explicit consideration, is a contract of insurance if there is any consideration received through other provisions or related agreements.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Enforcement

Non compliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 8 Effective Date

This regulation is effective April 1, 2013.

Section 9 History

Regulation 91-9 was effective August 1, 1991.

Regulation 91-9 was repealed and replaced by Regulation 5-1-2, effective July 1, 1993.

Regulation 5-1-12 was amended, effective January 1, 2002.

Regulation 5-1-12 was amended, effective June 1, 2012.

Regulation 5-1-12 was amended, effective April 1, 2013.

Regulation 5-1-13 EXEMPTIONS FROM RATE AND FORM FILING REQUIREMENTS FOR INSURERS PROVIDING COVERAGE TO EXEMPT COMMERCIAL POLICYHOLDERS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § § 10-1-109 and 10-4-1402, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish and implement rules concerning the definition and qualifications of an exempt commercial policyholder, the definition and qualifications of a risk manager, disclosure requirements for persons claiming status as exempt commercial policyholders, disclosure requirements for policies of Type II insurance issued to exempt commercial policyholders, and the data, documents, reports and other information to be maintained by insurers who are authorized to issue Type II insurance to exempt commercial policyholders. This regulation is made necessary by enactment into law of Colorado House Bill 99-1310, which requires the Commissioner to promulgate rules necessary to implement and administer § 10-4-1401 et. seq., C.R.S.

Section 3 Applicability

This regulation shall apply to all insurers authorized to issue Type II insurance (as defined below in Section 4.G.) to exempt commercial policyholders.

Section 4 Definitions

A. "Affiliated group" means two or more persons who are owned or controlled, directly or indirectly, by one of the constituent members of the group. As used in this definition, the term "controlled" means possessing, directly or indirectly, the power to direct or cause the direction of the management and policies of a person, whether through ownership of voting securities, or otherwise.

B. "Anti-competitive conduct" means engaging in, attempting to engage in, or threatening to engage in any conduct to monopolize or attempt to monopolize or to unreasonably restrain trade or commerce, or to combine or conspire with any other person to monopolize or attempt to

monopolize or to unreasonably restrain trade or commerce in any part of the business of insurance.

C. "Exempt commercial policyholder" means any person who applies for or procures any kind of Type II insurance, except any purchaser of title insurance, through the use of a risk manager employed or retained by such person, and who meets at least one of the following qualifications:

1. Purchased Type II insurance with aggregate premiums in the sum of at least fifty thousand dollars ($50,000.00) during the most recently completed calendar year;

2. Has a net worth of at least ten million dollars ($10 million) as reported in the policyholder's most recently issued financial statement, reviewed or audited by an independent certified public accountant;

3. Has annual net revenues or net sales of at least ten million dollars ($10 million) as reported in the policyholder's most recently issued financial statement, reviewed or audited by an independent certified public accountant;

4. Employs at least twenty-five (25) full-time employees, either individually or, if the policyholder is a member of an affiliated group, collectively with all members of the affiliated group;

5. If the policyholder is a nonprofit organization, has an annual operating budget of at least two million five hundred thousand dollars ($2.5 million) for the most recently completed calendar or fiscal year, whichever applies;

6. If the policyholder is a public entity (as defined in § 24-75-601(1), C.R.S.), has an operating budget of at least ten million dollars ($10 million) for the most recently completed calendar or fiscal year, whichever applies; or

7. If the policyholder is a municipality (as defined in § 31-1-101(6), C.R.S.), has a population of at least twenty thousand (20,000) as recorded in the latest Population of Municipalities and Counties published by the Division of Local Government, Colorado Department of Local Affairs.

D. "Person" has the same meaning set forth in § 2-4-401(8), C.R.S.

E. "Policyholder" means an exempt commercial policyholder.

F. "Risk manager" means an employee of the exempt commercial policyholder, or a third-party consultant retained by the policyholder who provides skilled services in loss prevention, loss reduction, or risk and insurance coverage analysis, and the purchase of insurance, and who possesses at least one of the following credentials:

1. A bachelor's or higher degree in risk management issued by an accredited college or university;

2. A designation as a Chartered Property and Casualty Underwriter (CPCU) issued by the American Institute for CPCU/Insurance Institute of America;

3. A designation as an Associate in Risk Management (ARM) issued by the American Institute for CPCU/Insurance Institute of America;

4. A designation as a Certified Risk Manager (CRM) issued by the National Alliance for Insurance Education & Research;

5. A designation as Fellow in Risk Management (FRM) issued by the Global Risk Management Institute/Risk & Insurance Management; or

6. At least seven (7) years of experience in one or more of the following areas of commercial property and casualty insurance: (i) risk financing, (ii) claims administration, (iii) loss prevention; or (iv) risk and insurance coverage analysis.

G. "Type II insurance" means insurance regulated by open competition between insurers, including fire, casualty, inland marine, and all other kinds of insurance subject to Part 4, Article 4, Title 10, C.R.S., but excluding insurance classified as Type I insurance by § 10-4-401(3)(a), C.R.S.

Section 5 Rules

A. Disclosure Requirements

1. At the time of soliciting an exempt commercial policyholder to purchase any kind of Type II insurance, the insurance producer, or the insurer in the case of a direct procurement from the insurer, shall disclose to the policyholder and the policyholder's risk manager, on a form created by the insurer, that a premium or rate may be quoted or a policy form may be used that is not subject to the rate and form filing requirements of the Colorado Division of Insurance.

2. If a third-party consultant is retained by the exempt commercial policyholder to act as the policyholder's risk manager, when a quote for any kind of Type II insurance is delivered to the policyholder, such consultant must disclose, in writing, the existence of any commission, fee, or contingency arrangement the third-party consultant has with the insurer.

3. Whenever a policy or binder of Type II insurance is first delivered to an exempt commercial policyholder, the insurance producer, or the insurer in the case of a direct procurement from the insurer, shall obtain from the policyholder a written certification on a form created by the insurer, dated and signed by a senior officer or senior manager of the policyholder, and the policyholder's risk manager, containing the following information and making the following certifications:

   a. The name of the insured;

   b. The name of the insurer;

   c. The name of the insurance producer who sold the policy or policies;

   d. The policy number or numbers;

   e. A brief description of the policy or policies of Type II insurance sold;

   f. List the requirement set forth in Section 4.C. above that the policyholder meets in qualifying as an exempt commercial policyholder; and

   g. Certification that the policyholder qualifies as an exempt commercial policyholder as defined pursuant to § 10-4-1402, C.R.S., and the rules of the Commissioner promulgated thereunder.

4. On any policy of Type II insurance sold to an exempt commercial policyholder, the insurer shall conspicuously place on the declaration page of the policy, and if a binder is issued, on the face of the binder, the following disclosure in at least ten-point, bold-faced type:

THE RATES, RATING PLANS, RESULTING PREMIUMS, AND THE POLICY FORMS FOR THIS POLICY ARE EXEMPT FROM THE FILING REQUIREMENTS UNDER COLORADO INSURANCE LAW AND THE RULES OF THE COLORADO INSURANCE COMMISSIONER.

5. Copies of the disclosures required in Section 5.A above shall be maintained by the insurer in the insurer's file for the exempt commercial policyholder. The insurer shall make such disclosures available for examination by the Commissioner or the Commissioner's delegatee at any reasonable hour.

B. Requirements for Maintaining Data, Documents, Reports, and Other Information

1. Any insurer who sells any kind of Type II insurance to an exempt commercial policyholder shall maintain records relating to such insurance sales as required by this rule. At a minimum, such records shall include: any data, statistics, rates, rating plans, rating systems, and underwriting rules used in underwriting and issuing such policies; claims-made policy forms; annual experience data on each risk insured, including, but not limited to, written premiums, written premiums at a manual rate, paid losses, outstanding losses, loss adjustment expenses, underwriting expenses, underwriting profits, and profits from contingencies; and complaint information required under Colorado Insurance Regulation 6-2-1.

2. The records described in Section 5.B. above shall be maintained by the insurer for five (5) years, and the insurer shall make such records available for examination by the Commissioner or the Commissioner's delegatee at any reasonable hour.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of the regulation shall not be affected.

Section 7 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 8 Effective Date

This regulation shall become effective on November 1, 2012.

Section 9 History

New Regulation effective January 15, 2000.

Amended Regulation effective August 1, 2006.

Amended Regulation effective November 1, 2012.

Regulation 5-1-14 PENALTIES FOR FAILURE TO PROMPTLY ADDRESS PROPERTY AND CASUALTY FIRST PARTY CLAIMS

Section 1 Authority

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance pursuant to § § 10-1-109 and 10-3-1110, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to describe the procedure and circumstances under which penalties will be imposed for failure to make timely decisions and/or payment on first party claims.

Section 3 Applicability

This rule shall apply to all insurers authorized to write property and casualty insurance in the state of Colorado.

Section 4 Rules

A. Timely Decisions and Payment of Benefits

1. Penalties

a. All insurers authorized to write property and casualty insurance policies in Colorado, shall make a decision on claims and/or pay benefits due under the policy within sixty (60) days after receipt of a valid and complete claim unless there is a reasonable dispute between the parties concerning such claim, and provided the insured has complied with the terms and conditions of the policy of insurance.

b. If an insurer fails to make a decision and/or pay benefits due under the policy within sixty (60) days after a valid and complete claim has been received, and there is not a reasonable dispute between the parties, and the insured has complied with the terms and conditions of the policy of insurance, the Commissioner of Insurance may impose the following penalties to be paid by the insurer to the insured:

(1) If the claim is $100.00 or less, the penalty shall not be more than $20.00;

(2) If the claim is more than $100.00, the penalty shall be 8 percent annual interest on the amount of benefits due, computed from the latest of the time a valid and complete claim is received, the reasonable dispute was resolved, or the insured complied with the terms and conditions of the policy, until the time the benefits due are paid by the insurer.

c. In addition to such penalties payable to the claimant, the Commissioner of Insurance, after notice and hearing, may assess a civil penalty against any insurer of $100.00 per day for each day benefit payments are delayed more than sixty (60) days after a valid and complete filing of the claim unless there is a reasonable dispute between the parties concerning such claim.

2. Conditions

a. A valid and complete claim is deemed received by the insurer when:

(1) All information and documents necessary to prove the insured's claim have been received by the insurer;

(2) A reasonable investigation of the information submitted has been completed by the insurer, in compliance with §10-3-1104, C.R.S.;

(3) The terms and conditions of the policy have been complied with by the insured;

(4) Coverage under the policy for the insured has been established for the claim submitted;

(5) There are no indicators on the claim requiring additional investigation before a decision can be made; and/or

(6) All repairs have been satisfactorily completed and the insured has given authorization to pay; and/or

(7) Negotiations or appraisals to determine the value of the claim have been completed; and/or

(8) Any litigation on the claim has been finally and fully adjudicated.

b. A reasonable dispute may include, but is not limited to:

(1) Information necessary to make a decision on the claim has not been submitted or obtained;

(2) Conflicting information is submitted or obtained and additional investigation is necessary;

(3) The insured is not in compliance with the terms and conditions of the policy;

(4) Coverage under the policy for the loss claimed has not been determined;

(5) Indicators are present in the application or submission of the claim and additional investigation is necessary;

(6) Litigation is commenced on the claim; or

(7) Negotiations or appraisals are in process to determine the value of a claim.

3. A good faith offer by the insurer to the insured within sixty (60) days after the receipt of a valid and complete claim satisfies the requirements under this regulation.

4. If claims for benefits are processed by a third party administrator or other entity acting on behalf of the insurer, or if the insured is represented by a third party, the failure of the third party to comply with the terms of the policy or this regulation, shall be the failure of the insurer or insured respectively.

5. In all actions initiated under this regulation, the insured shall have the burden of proving to the Commissioner of Insurance that he/she submitted a valid and complete claim to the insurer.

6. The insurer shall have the burden of proving to the Commissioner of Insurance that a reasonable dispute existed.

7. If it is determined that benefits are due to the insured, the insurer must issue a payment to the insured within sixty (60) days of a valid and complete claim being received, if all the conditions in the definition herein are met.

8. In the event of a significant catastrophe resulting in multiple claims, an insurer may notify the Commissioner of Insurance of the nature and extent of the catastrophe and request a deviation or exemption from this regulation.

B. Reasonable Investigation

1. The Commissioner of Insurance recognizes that the scope of an investigation can be determined, in part, to be reasonable based on the terms and conditions of the policy and the facts and circumstances of each claim. It may include, but is not limited to:

   a. Reports from police or other law or fire enforcement authorities;

   b. Scene investigations;

   c. Photographs, videotaped evidence;

   d. Surveillance information;

   e. Statements or reports from the insureds, claimants, other parties, witnesses, or anyone who may have knowledge of elements of the claim;

   f. Repair estimates;

   g. Reports from relevant experts;

   h. Credit reports and financial information;

   i. Information on prior, concurrent or subsequent claims; or

   j. Other relevant information.

2. Documentation that a reasonable investigation has been conducted shall be maintained in the claim file. Such documentation may include, but is not limited to:

   a. Adjuster's log notes;

   b. Copies of written communications;

   c. Written reports used in the investigation of a claim;

d. Status reports;

e. Evidence of payments; or

f. Other relevant information.

3. When an investigation is incomplete or is otherwise continued and the insurer has not paid the claim within the time required under section 4.A.1. above, the insurer shall immediately notify the insured or the insured's representative, if applicable, of the reason(s) the claim has not been paid. Additionally, if the claim is not paid within the time requirement under section 4.A.1., above, the insurer shall, every thirty (30) days thereafter, send to the insured or the insured's representative a letter setting forth the reason(s) additional time is needed for investigation. This requirement is not intended to alter any terms of the contract between the insurer and insured regarding their respective rights, duties, and obligations and the law involving such matters.

4. If the claim has not been paid because an investigation is underway, the insurer shall document in the claim file the actions being taken to investigate the claim and the efforts being made to promptly conclude the investigation.

5. The claim file documentation required by this regulation will be reviewed by the Division of Insurance during an investigation of a complaint or during a market conduct examination to determine if the requirements of §10-3-1104(1)(h), C.R.S. and this regulation have been met.

Section 5 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 6 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 7 Effective Date

This regulation shall become effective on September 1, 2012.

Section 8 History

New regulation 5-1-14 effective May 1, 2001.

Amended regulation effective December 1, 2001.

Amended regulation effective February 1, 2004.

Amended regulation effective September 1, 2012.

Regulation 5-1-15 NOTIFICATION TO ADDITIONAL INSUREDS WHOSE INTERESTS ARE AFFECTED BY A CLAIM UNDER A GENERAL LIABILITY POLICY

Section 1 Authority

Section 1 Authority

This regulation is promulgated pursuant to § § 10-1-109 and 10-1-131, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to implement rules concerning notification to additional insureds whose interests are affected by a claim on a general liability policy.

Section 3 Applicability

This regulation shall apply to all insurers authorized to issue general liability policies in the state of Colorado.

Section 4 Definitions

A. “General liability policy” means any insurance policy that provides insurance against negligent acts or omissions related to any contractor or completed operations activity.

B. “Additional insured by endorsement” means a person or entity that is named on an endorsement to the general liability policy.

C. “Reasonable period of time” means within ninety (90) calendar days after a liability claim is received, provided the insurer is able to identify the additional insured by endorsement based on a review of the records of the insurance company or information obtained from the named insured.

Section 5 Rules

Notice Requirements

A. An insurer shall notify any additional insured by endorsement on a general liability policy, whose interests are affected by a liability claim, of the results of the insurer's investigation of such claim and the status of the claim within a reasonable period of time.

B. Notice to the additional insured of the results of the insurer's investigation of the claim and the status of the claim shall be satisfied by providing:

1. A statement confirming or denying coverage;

2. If coverage has been denied, the reason for the denial; or

3. If coverage has not been determined, a copy of the reservation of rights letter.

C. A statement of the applicable policy language shall be a sufficient statement of an insurer's reason for denial of coverage.

D. In the event a copy of the reservation of rights letter has been sent to the additional insured by endorsement pursuant to subparagraph 3, and coverage is subsequently confirmed or denied, notice pursuant to subparagraphs 1 or 2 shall be given within ninety (90) days after such coverage determination.

E. This regulation shall not apply to claims under a general liability policy upon which a lawsuit has been filed.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 8 Effective Date

This regulation is effective August 1, 2012.

Section 9 History

New Regulation, effective May 1, 2001.

Amended Regulation, effective January 1, 2007.

Amended Regulation, effective August 1, 2012.

Regulation 5-1-16 Repealed effective 02/01/2005

Repealed *effective 02/01/2005*

Regulation 5-1-17 AVAILABILITY OF FIRE INSURANCE DURING WILDFIRES

Section 1 Authority

Section 2 Scope and Purpose

Section 3 Applicability

Section 4 Definitions

Section 5 Rules

Section 6 Severability

Section 7 Enforcement

Section 8 Effective Date

Section 9 History

Section 1 Authority

This regulation is promulgated under the authority of § § 10-1-109 and 10-4-110.9(4), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to provide a rule to implement standards concerning the availability of fire insurance during wildfires within a federally designated disaster area in Colorado.

Section 3 Applicability

This rule shall apply to all insurers a uthorized to write property insurance in the state of Colorado.

Section 4 Definitions

A. "Fire insurance policy" means a policy of insurance on real or personal property, which includes non-commercial dwelling fire, homeowners, tenant homeowners, or mobile homeowners.

B. "Immediately threatened area" means an area located within a federally designated disaster area, because of wildfires, based on such property's zip code, county location, or distance from any wildfire. Absent a written determination by a government official, or a determination otherwise published by a government official, of the area defined as an immediately threatened area, such term shall mean the area under a lawful order to evacuate or an area under a lawful pre-evacuation order.

C. "Reasonable actions to reduce the risk of fire" means underwriting requirements, which may include, but are not limited to:

1. Requiring the property owner to provide a defensible space around the structure;

2. Requiring the property owner to clean out debris and leaves from gutters and downspouts as well as from beneath decks and porches; and

3. Adding or enhancing fire suppression systems.

Section 5 Rules

A. Insurers shall not refuse to issue a fire insurance policy for a property based on the property's zip code, county location, or distance from any wildfire, unless the property is located in an immediately threatened area.

B. Insurers shall not refuse to renew a fire insurance policy for a property located within an immediately threatened area for any reason that is related to existing wildfires.

C. Insurers, as a condition of renewal, may require a property owner to take reasonable actions to reduce the risk of fire to such property. Such reasonable actions to reduce the risk of fire shall be specified in the insurer's written underwriting guidelines.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 8 Effective Date

New regulation effective March 2, 2003.

Amended regulation effective September 1, 2012.

Section 9 History

New regulation effective March 2, 2003.

Amended regulation effective September 1, 2012.

Regulation 5-1-18 CONCERNING THE ELEMENTS OF CERTIFICATION FOR CERTAIN PROPERTY AND CASUALTY, CREDIT, AND EXCESS LOSS FORMS AND CONTRACTS

Section 1 Authority

This regulation is promulgated pursuant to § § 10-1-109, 10-3-1110, 10-4-419, 10-4-633, 10-4-633.5, 10-10-109, and 10-16-119, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to promulgate rules applicable to the filing of property and casualty and credit forms and contracts that include, but are not limited to, the Family Medical Leave Act (FMLA), unemployment, credit property, excess loss insurance new policy forms, new policy form listings, annual reports of policy forms, and certifications of policy forms.

Section 3 Applicability

This regulation applies to all insurers and other entities authorized to conduct business in Colorado who are required to fully execute and file a certification form and complete the Form Schedule Tab in the System for Electronic Rate and Form Filings (SERFF). This includes insurers and authorized entities which provide one or more of the following products: private passenger automobile insurance; commercial automobile insurance with the "individually-owned private passenger automobile-type" endorsement; claims-made liability insurance; credit insurance; and excess loss insurance used in conjunction with self-insured employer benefit plans under the federal "Employee Retirement Income Security Act" (ERISA). This regulation replaces Emergency Regulation 13-E-04 in its entirety.

Section 4 Definitions

A. "Annual Report for claims-made liability insurance" means, for the purposes of this regulation, the completion of the Form Schedule Tab in SERFF, including the documents and information listed in section 5.K. of this regulation.

B. "Annual Report for commercial automobile with individually-owned private passenger automobile-type" endorsement means, for the purposes of this regulation, the completion of the Form Schedule Tab in SERFF, including the documents and information listed in section 5.L. of this regulation.

C. "Annual Report for credit insurance" means, for the purposes of this regulation, the completion of the Form Schedule Tab in SERFF, including the documents and information listed in section 5.M. of this regulation.

D. "Annual Report for private passenger automobile insurance" means, for purposes of this regulation, the completion of the Form Schedule Tab in SERFF, including the documents and information listed in section 5.N. of this regulation.

E. "Certification of compliance" means, for the purposes of this regulation, the form that contains the necessary elements of certification, as determined by the commissioner, which has been signed by the designated officer of the insurer.

F. "Certification of compliance for excess loss insurance" means, for the purposes of this regulation, a certification form, which contains the elements of certification as determined by the commissioner, signed by a designated officer of the insurer, and used in conjunction with self-insured employer benefit plans under ERISA.

G. "Credit insurance" for the purposes of this regulation shall have the same meaning set forth in § 10-10-103(2), C.R.S.

H. "Effective date" means, for the purposes of this regulation, the effective date listed in the General Information Tab of SERFF.

I. "Excess loss insurance" means, for the purposes of this regulation, the excess loss insurance provided in conjunction with self-insured employer benefit plans under ERISA, and that complies with the requirements set forth in § 10-16-119, C.R.S.

J. "Licensed insurer" means, for the purposes of this regulation, any authorized organization that provides private passenger automobile insurance, commercial automobile insurance with the

"individually-owned private passenger automobile-type" endorsement, claims-made liability insurance, credit insurance, and excess loss insurance.

K. "Listing of New Policy Forms for claims-made liability insurance" shall mean completing the Form Schedule Tab in SERFF, including the documents and information listed in section 5.O. of this regulation.

L. "Listing of New Policy Forms for commercial automobile with individually-owned private passenger automobile-type" endorsement shall mean completing the Form Schedule Tab in SERFF, including the documents and information listed in section 5.P. of this regulation.

M. "Listing of New Policy Forms for credit insurance" shall mean completing the Form Schedule Tab in SERFF, including the documents and information listed in section 5.Q. of this regulation.

N. "Listing of New Policy Forms for excess loss insurance" shall mean completing the Form Schedule Tab in SERFF, including the documents and information listed in section 5.R. of this regulation.

O. "Listing of New Policy Forms for private passenger automobile insurance" shall mean completing the Form Schedule Tab in SERFF, including the documents and information listed in section 5.S. of this regulation.

P. "Officer of an insurer" means, for the purposes of this regulation, the president, vice president, assistant vice president, corporate secretary, assistant corporate secretary, chief executive officer (CEO), chief financial officer (CFO), general counsel, or actuary who is also a corporate officer, or any officer appointed by the board of directors.

Q. "Signature" includes an electronic signature as defined in § 24-71.3-102, C.R.S.

Section 5 Rules

A. At least thirty-one (31) days prior to using any new form (except excess loss insurance forms, which may be filed concurrently), each insurer subject to the provisions of this regulation must file a certification of compliance form in a format prescribed by the commissioner, and complete the Form Schedule Tab in SERFF.

B. Excess loss insurance form certifications are to be filed prior to, or concurrently with, the use of the form by each insurer subject to the provisions of this regulation. This filing must include a certification of compliance form in a format prescribed by the commissioner and a completed Form Schedule Tab in SERFF. Excess loss insurance form filings require the actual forms to be submitted in the Form Schedule Tab.

C. An annual report of policy forms must be filed no later than July 1 of each year. These annual reports will consist of a completed Form Schedule Tab in SERFF, and must include a certification of compliance. The filing will include the readability score where required by law. The following entities must complete and submit this report:

1. Private passenger automobile insurers;

2. Commercial automobile insurers with "individually-owned private passenger automobile-type" endorsements;

3. Claims-made liability insurers; and

4. Credit insurers.

D. Excess loss insurance used in conjunction with ERISA does not require the filing of an annual report of policy forms.

E. Certification requirements.

1. The elements of certification, as determined by the commissioner, are as follows:

a. The name of the licensed insurer;

b. A statement that the officer signing the certification form is knowledgeable of the specific type of insurance being certified: private passenger automobile insurance; commercial automobile insurance with the "individually-owned private passenger automobile-type" endorsement; claims-made liability insurance; credit insurance; or excess loss insurance;

c. A statement that the officer signing the certification form has carefully reviewed the policy forms, endorsements, or disclosure forms on the Listing of New Policy Forms or Annual Report, or in the case of excess loss insurance, a statement that the actual forms are attached;

d. A statement that the officer signing the certification form has read and understands each applicable law, regulation, and bulletin;

e. A statement that the officer signing the certification form is aware of applicable penalties for certification of a noncomplying form or contract;

f. A statement that the officer signing the certification form certifies:

(1) For Listings of New Policy Forms and Annual Reports for claims-made liability insurance, the certification must include a statement that the policy forms identified in the Listing of New Policy Forms or Annual Report provide all applicable mandated coverages and that such forms are in full compliance with all Colorado insurance laws and regulations;

(2) For Listing of New Policy Forms and Annual reports for credit insurance, the certification must include a statement that the policy forms identified in the Listing of New Policy Forms or Annual Report provide all applicable mandated coverages and that such forms are in full compliance with all Colorado insurance laws and regulations;

(3) For Listings of New Policy Forms and Annual Reports for private passenger automobile insurance and commercial automobile insurance with the "individually-owned private passenger automobile-type" endorsement, the certification must include a statement that the policy forms identified in the Listing of New Policy Forms or Annual Report provide all applicable mandated coverages and that such forms are in full compliance with all Colorado insurance laws and regulations.

g. The name and title of the officer signing the certification form and the date the certification form is signed; and

h. The original signature of the officer. Signature stamps, photocopies or a signature on behalf of the officer are <u>not</u> acceptable. Electronic signatures must be in compliance with § 24-71.3-102, C.R.S., and applicable regulations.

2. The elements of certification must be included in:

a. Form PPA (Colorado Automobile Private Passenger Insurance Certification Form);

b. Form CA (Colorado Commercial Automobile with Individually-Owned Private Passenger Automobile-Type Insurance Certification Form);

c. Form CLM (Claims-Made Liability Insurance Certification Form);

d. Form CI (Colorado Credit Insurance Policy Certification Form); and

e. Form Excess Loss (Colorado Excess Loss Insurance for Self-Insured Employer Benefit Plans under ERISA Certification Form).

F. If the individual signing the certification is not an officer of an insurer as defined in Section 4.P, documentation must be included that shows that this individual has been appointed as an officer of the organization by the board of directors. This documentation is to be submitted with every filing.

G. If an insurer uses the optional method of electronic dissemination of newly issued or renewed policy forms or endorsements, the insurer must comply with Colorado's Uniform Electronic Transaction Act (UETA) § 24-71.3-101 et seq., C.R.S. UETA guidance is provided by the Colorado Office of Information Technology and the Colorado Division of Insurance.

H. All filings submitted in SERFF, which is the format prescribed by the commissioner, must have the Form Schedule Tab completed with the form name, unique form number for new policies, edition date, form type, action, action specific data, and the readability score, where required by law. Only the Colorado Private Passenger Automobile Insurance Summary Disclosure Form and the excess loss forms must be attached to filings.

I. If an "individually-owned private passenger automobile-type" endorsement is attached to a commercial automobile insurance policy, the filing and certification requirements of Part 6 of Article 4, Title 10, C.R.S., apply to the policy forms, endorsements, and cancellation notices. The certification requirements also apply to renewal notices, disclosure forms, notices of proposed premium increases, notices of reductions in coverage, and any other such forms as requested by the commissioner, that are currently in use and issued or delivered, or intended to be used and issued or delivered, to any policyholder in Colorado, and that are used, or intended to be used, with any commercial automobile insurance policy.

J. If an "individually-owned private passenger automobile-type" endorsement is attached to a commercial automobile insurance policy, the insurer must comply with all of the private passenger automobile certification requirements.

K. In order to file an "Annual Report for claims-made liability insurance" the insurer must complete the Form Schedule Tab in SERFF. The report must also include all claims-made liability insurance policy forms, endorsements, disclosure forms, and evidence of coverage currently in use and issued or delivered to any policyholder in Colorado. Attaching the actual forms is not required.

L. In order to file an "Annual Report for commercial automobile insurance with individually-owned private passenger automobile-type" endorsement, the insurer must complete the Form Schedule Tab in SERFF. The report must include all commercial automobile policy forms, endorsements, cancellation notices, renewal notices, disclosure forms, notices of proposed premium increases, notices of reductions in coverage, and any other such forms as requested by the commissioner currently in use, and issued or delivered to any policyholder in Colorado. Attaching the actual forms is not required.

M. In order to file an "Annual Report for credit insurance" the insurer must complete the Form Schedule Tab in SERFF. The report must also include all credit insurance policy forms, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements, and riders issued or delivered to any policyholder in Colorado. Attaching the actual forms is not required.

N. In order to file an "Annual Report for private passenger automobile insurance" the insurer must complete the Form Schedule Tab in SERFF. The report must include all private passenger automobile policy forms, endorsements, cancellation notices, renewal notices, disclosure forms, notices of proposed premium increases, notices of reductions in coverage, and any other such forms as requested by the commissioner currently in use, and issued or delivered to any policyholder in Colorado. The readability score must be included where required by law. Only the Colorado Private Passenger Automobile Insurance Summary Disclosure Form must be attached in SERFF.

O. In order to file a "Listing of New Policy Forms for claims-made liability insurance" the insurer must complete the Form Schedule Tab in SERFF. The listing must include any new claims-made liability insurance policy forms, certificates, contracts of insurance, or any portion thereof which provides coverage on a claims-made basis that is issued or delivered to any policyholder in Colorado. Attaching the actual forms is not required, but the information required in H. of this section must be included.

P. In order to file a "Listing of New Policy Forms for commercial automobile insurance with individually-owned private passenger automobile-type" endorsement, the insurer must complete the Form Schedule Tab in SERFF. The listing must include any new commercial automobile policy forms, endorsements, cancellation notices, renewal notices, disclosure forms, notices of proposed premium increases, notices of reductions in coverage, and any other such forms as requested by the commissioner issued or delivered to any policyholder in Colorado. Attaching the actual forms is not required, but the information required in H. of this section must be included.

Q. In order to file a "Listing of New Policy forms for credit insurance" the insurer must complete the Form Schedule Tab in SERFF. The listing must include all policies, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements, and riders delivered or issued for delivery to any policyholder in Colorado. Attaching the actual forms is not required, but the information required in H. of this section must be included.

R. In order to file a "Listing of New Policy forms for excess loss insurance," the insurer must complete the Form Schedule Tab in SERFF. The listing must include, and have attached, all new policy forms issued or delivered to any policyholder in Colorado, including the actual excess loss forms. The information required in H. of this section must also be included.

S. In order to file a "Listing of New Policy Forms for private passenger automobile insurance" the insurer must complete the Form Schedule Tab in SERFF. The listing must include any new private passenger automobile policy forms, endorsements, cancellation notices, renewal notices, disclosure forms, notices of proposed premium increases, notices of reductions in coverage, and any other such forms as requested by the commissioner, issued or delivered to any policyholder in Colorado. The readability score must be included where required by law. Only the Colorado Private Passenger Automobile Insurance Summary Disclosure Form must be attached in SERFF, but the information required in H. of this section must be included for all listed forms.

Section 6 Readability

A. Effective January 1, 2012, insurers writing private passenger automobile insurance policies must include the Flesch-Kincaid grade level or the Flesch Read Ease score in each electronic filing. The Flesch-Kincaid grade level must not exceed the tenth grade level. The Flesch Read Ease score must not be less than 50.

B. Insurers may choose either the Flesch-Kincaid grade level formula or the Flesch Read Ease formula to generate a readability score. However, once a formula has been selected from these two (2) formulas, the selected formula must be used consistently for all text being scored for that particular policy.

C. At the option of the insurers, riders, endorsements, applications, and other forms made a part of the policy, may be scored either as a separate form or as part of the policy with which they will be used.

D. For the purposes of the readability score, only forms that are made part of the policy are required to comply with the readability score. Cancellation notices, renewal notices, disclosure forms, and notices of reductions in coverage do not require a readability score.

E. Readability scores are not required for commercial automobile insurance coverage.

F. Readability scores are not required for claims-made insurance coverage.

Section 7 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 8 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 9 Effective Date

This regulation shall become effective on October 1, 2013.

Section 10 History

Originally issued as Emergency Regulation 92-1, effective July 22, 1992.

Final Regulation 1-1-6 effective June 1, 1994.

Amended Regulation 1-1-6 effective February 1, 2002.

Amended Regulation 1-1-6 effective June 1, 2003.

Sections 1, 2, 3, 8 and 9 amended effective February 1, 2004.

Amended Regulation effective January 1, 2012.

Regulation 5-1-18 effective October 1, 2013.

Regulation 5-1-19 PROHIBITED ADVERSE ACTIONS APPLICABLE TO VICTIMS OF THE 2013 COLORADO FLOODS

Section 1 Authority

Section 2 Scope and Purpose

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § § 10-1-109 and 10-3-1110, C.R.S.

Section 2 Scope and Purpose

The 2013 floods that affected many Colorado counties caused significant losses and damages to Colorado consumers. The Division of Insurance (Division) is aware that property was and may still be inaccessible and unoccupied while roads, bridges, utilities and other infrastructure in Colorado communities was or is being repaired. The purpose of this regulation is to provide a rule to protect the affected consumers of the 2013 floods by prohibiting certain adverse actions during the recovery period. This regulation replaces and supercedes emergency regulation 13-E-14 in its entirety.

Section 3 Applicability

This rule shall apply to all insurers licensed to conduct business in Colorado.

Section 4 Definitions

"2013 floods" means, for the purposes of this regulation, the Colorado flooding event that began on September 11, 2013

Section 5 Rules

A. An insurer shall not cancel or non-renew a property insurance policy if the property has not been damaged but is otherwise unoccupied because the property owner, business owner or renter is unable to return to the property for reasons beyond his or her control, including but not limited to:

1. The roads to the property are no longer accessible;

2. The affected city or county has not allowed residents to return to the property; or

3. The property is uninhabitable because of the lack of utilities such as gas and water.

B. If the Federal Emergency Management Agency (FEMA) requires coverage denial to provide the consumer financial assistance, the insurer shall not take an adverse action because of this requirement.

C. An insurer shall not consider damage that arose subsequent to the 2013 floods, as related to the 2013 floods, unless it was directly caused by the 2013 floods.

D. In the event of a claim received subsequent to the 2013 floods, an insurer must consider the factors outlined in Subsection 5.A. above when determining whether an insured took reasonable actions to protect the property.

E. Personal property temporarily removed from the insured premises because of the 2013 floods, must be covered at the same amount as if the property was located at the insured premises until the real property is re-occupied.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of the regulation shall not be affected.

Section 7 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 8 Effective Date

This regulation is effective February 14, 2014

Section 9 History

Emergency Regulation 13-E-14 effective October 25, 2013

Regulation Effective February 14, 2014

Regulation 5-2-1 [Repealed eff. 06/01/2012.]

Regulation 5-2-2 CONCERNING RENEWAL OF AUTOMOBILE INSURANCE POLICIES – EXCLUDED NAMED DRIVERS

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § § 10-1-109(1) and 10-4-601.5, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to require each renewal policy of automobile insurance to disclose excluded named drivers as applicable.

Section 3 Applicability

This regulation applies to all complying policies of automobile insurance.

Section 4 Rules

Each insurer renewing a complying policy of automobile insurance as defined in § 10-4-601(2), C.R.S., which policy excludes a named driver under the provisions of § 10-4-630, C.R.S., shall by conspicuous printed notice re-notify the named insured at the time of each policy renewal. Failure to so re-notify the named insured of an excluded driver at the time of policy renewal shall make such exclusion void for all policy coverage.

Section 5 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 6 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 7 Effective Date

This regulation shall become effective on July 1, 2012.

Section 8 History

Originally issued as Regulation 78-9, effective June 11, 1979.

Re-codified as Regulation 5-2-2, effective June 1, 1992.

Regulation Amended, effective May 1, 2003.

Regulation Amended, effective February 4, 2004.

Regulation Amended, effective February 1, 2006.

Amended Regulation 5-2-2, effective July 1, 2012.

Regulation 5-2-3 Repealed Effective 06/01/2012

Regulation 5-2-5 Repealed Effective 06/01/2012

Regulation 5-2-6 Repealed Effective 06/01/2012

Regulation 5-2-7 Repealed Effective 06/01/2012

Regulation 5-2-8 TIMELY PAYMENT OF PERSONAL INJURY PROTECTION BENEFITS

Section 1 Authority

This regulation was originally promulgated by the Commissioner of Insurance pursuant to § § 10-1-109, 10-4-704, 10-4-708 (1.3) (effective until July 1, 2003 except for claims incurred under policies lawfully in effect as described in this regulation), and 10-3-1110(1), C.R.S. This Regulation is being amended under the authority of § 10-1-109, C.R.S.

Section 2 Scope and Purpose

The purpose of this amended regulation is to update the regulation to include only those provisions that govern the continued handling of claims under § § 10-4-701, C.R.S., et seq., as in effect on June 30, 2003. Additionally, the regulation sets forth the requirements for establishing proof of the fact and amount of expenses incurred, provides for notices by insurers, and makes certain acts of insurers presumptive unfair or deceptive acts or practices.

Section 3 Applicability

The Colorado Reparations (No-Fault) Act was repealed effective July 1, 2003. Automobile insurance policies with personal injury protection (PIP) benefits issued or renewed prior to July 1, 2003 will continue to incur PIP claims until such benefits do not apply any longer. This regulation applies to claims occurring under No-Fault policies issued prior to July 1, 2003.

Section 4 Rules

A. Prompt Investigation of PIP Claims.

1. Section 10-3-1104 (1)(h)(III), C.R.S., requires insurers to adopt and implement reasonable standards for the prompt investigation of claims. An insurer is also required to promptly investigate a claim while it is accumulating claim's expense.

2. Whenever an insurer requires that an application for benefits form be submitted by an injured party, the insurer shall forward the form to the injured party upon notification of the injury.

3. When an investigation is incomplete or is otherwise continued, the insurer shall, within 30 days after the documents are received as described in C. below and every 30 days thereafter, send to the claimant or the claimant's representative, and the health care provider, if applicable, a letter setting forth the reasons additional time is needed for investigation.

4. Where additional information is required to complete an investigation, the insurer shall request such information, specifically listing the items needed to complete the investigation. A copy of such request shall be delivered to the claimant, the claimant's representative, the health care provider or other person or entity most likely in possession of the required information.

B. Prompt Payment of PIP Benefits.

1. Section 10-4-708(1), C.R.S., provides that benefits under the coverages enumerated in §10-4-706, C.R.S., are overdue if not paid within 30 days after the insurer receives reasonable proof of the fact and amount of the expenses incurred.

2. Section 10-4-708(1), C.R.S., allows for the accumulation of claims expense for periods not exceeding one month and provides that benefits are not overdue if paid within 15 days after the end of a defined period of accumulation. An insurer is permitted by this statute to pay a bill within 15 days after the end of a defined accumulation period only when there is a reasonable likelihood that multiple providers are involved and more than one bill is received during the accumulation period.

C. Requirements Establishing Proof of the Fact and Amount of Expenses Incurred.

1. Medical and Rehabilitative PIP benefits. In the usual case, for purposes of triggering the 30-day time period described in §10-4-708(1), C.R.S., the following documents are sufficient to establish reasonable proof of the fact and amount of the expenses incurred for covered medical and rehabilitative PIP benefits:

   a. A properly executed application for benefits from the PIP claimant; and

   b. An initial notice to the insurer from the provider of benefits which meets the requirements of §10-4-708.5, C.R.S., or a billing statement for the procedure or treatment which complies with §10-4-708.6, C.R.S., and includes pursuant to §10-4-708.5, C.R.S., the following:

      (1) The name and address of the treating health care provider;

      (2) The evaluation or diagnosis, and the medical procedure performed or the medical treatment provided; and

      (3) An itemized statement of charges corresponding to the medical service or treatment provided along with corresponding dates of services.

2. PIP Wage Loss Benefits. In the usual case, if the claimant is pursuing covered PIP wage loss benefits, the following documents are sufficient to establish proof of the fact and amount of wage loss incurred:

   a. A properly executed application for benefits from the PIP claimant; and

   b. Written verification by a health care provider that the claimant is not able to perform his/her work as a result of the injury; and

   c. Written verification of employment and income; or

   d. Documentation of self-employment at the time of the loss through:

      (1) Payroll receipts; or

(2) Copies of prior year income tax filings and business records evidencing the claimant is engaged in a business.

(3) If the claimant has hired a replacement worker, proof of payment for the replacement worker should also be provided.

3. PIP Death Benefits. In the usual case, if covered PIP death benefits are pursued as a result of an automobile accident, the following documents are sufficient to establish proof of the fact and amount of death benefit expenses incurred:

a. A properly executed application from the claimants representative; and

b. A certified copy of the death certificate.

D. Notice Requirements.

1. If an insurer does not pay a claim for benefits under §10-4-706, C.R.S., within 30 days of receipt of the appropriate documents described in this regulation and as set forth in §10-4-708, C.R.S., the insurer shall immediately notify the PIP claimant or the claimant's representative and the health care provider, if applicable, of the reason(s) the claim has not been paid.

2. If the claim has not been paid because an investigation is underway, the insurer shall document in the claim file the actions being taken to investigate the claim and the efforts being made to promptly conclude the investigation.

E. Unfair Method of Competition and Unfair or Deceptive Acts of Practices in the Business of Insurance.

1. Pursuant to §10-3-1104(1)(h)(III) and (IV), C.R.S., the following are presumptive violations of said sections:

a. Denying a claim, either in whole or in part, or otherwise reducing payment for PIP benefits arising under automobile insurance policies when the denial or reduction is based solely on any of the following:

(1) An accident reconstruction report, a bio-mechanical engineering report or any other low impact study whether prepared by the insurer or any other governmental or private entity. Although such report may be part of the investigative process, additional medical information from the treating provider or an IME must be considered in the analysis; or

(2) Relying upon utilization review prescribing a prospective fixed treatment plan as a final determination of benefits. Any insurer intending to deny PIP benefits upon completion of a course of treatment over the objection of the claimant shall not deny future benefits upon completion of the course of treatment without conducting further investigation, including but not limited to, a current evaluation to determine the necessity of further treatment.

b. Reducing payment of health care provider bills outside of a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO) in connection with the payment of PIP benefits pursuant to §10-4-706(1), C.R.S., based upon the recommendations of a medical data processing firm or other pricing entity unless the insurer reviews on an annual or more frequent basis whether the data in the vendor's database is current, accurate, and sufficient to make recommendations

regarding reasonable charges for bills submitted as part of PIP claims. Further, any PIP insurer using such repricing firms or entities shall consider additional information given to it by a health care provider and shall make decisions independent of the vendor's recommendations when appropriate.

F. Records of Health Care Providers and Policy Contract Compliance.

Nothing herein shall preclude an insurer from requesting or obtaining medical records from a health care provider or to negate a contractual requirement that an injured party comply with a valid condition in the policy regarding eligibility for receipt of benefits.

G. Documentation

The claim file documentation required by this regulation will be reviewed by the Division of Insurance during an investigation of a complaint or during a market conduct examination to determine if the requirements of § §10-4-708(1) and 10-3-1104 (1) (h), C.R.S. have been met.

Section 5 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 6 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 7 Effective Date

This amended regulation shall become effective on September 1, 2012.

Section 8 History

New regulation effective November 1, 1997.

Amended regulation effective September 1, 2000.

Amended regulation effective February 1, 2004.

Amended regulation effective September 1, 2012.

Amended Regulation 5-2-9 - Personal Injury Protection Examination Program

Section 1 Authority

Section 2 Background and Purpose

Section 3 Applicability and Scope

Section 4 Rule

Section 5 Enforcement

Section 6 Severability and Scope

Section 7 Effective Date

Section 8 History

Section 1 Authority

This regulation is promulgated by the Commissioner under the authority granted in § § 10-1-109, and 10-4-706(6)(a), C.R.S.2002 (effective until July 1, 2003 except for claims incurred under policies lawfully in effect as described in this regulation).

Section 2 Background and Purpose

The purpose of this regulation is to provide rules for the PIP examination program whenever disputes arise on PIP claims.

Section 3 Applicability and Scope

The Colorado Reparations (No-Fault) Act was repealed effective July 1, 2003. Automobile insurance policies with personal injury protection (PIP) benefits issued or renewed prior to July 1, 2003 will continue to incur PIP claims and disputes on such claims until PIP benefits do not apply any longer.

Section 4 Rule

All statutory cites contained in this section reflecting § § 10-4-701 through 10-4-726, C.R.S. 2002, shall refer to the statutes in effect as of June 30, 2003.

A. DEFINITIONS

1. Claim: A request for payment of a PIP benefit submitted to the insurer on or after January 1, 1997 for which reasonable proof under Regulation 5-2-8 has been provided and which was not subject to an Independent Medical Examination (IME) prior to January 1, 1997.

2. Days: When referred to in this regulation shall mean business days.

3. Disputed PIP Claim: A claim, or any portion thereof, which the insurer is either investigating pursuant to Regulation 5-2-8 or gives notice that it is denying. A disputed PIP claim may include a claim the insurer is investigating, even though the insurer has paid or may be paying other claims for benefits.

4. IME Program Administrator: The person or entity selected by the Commissioner to administer the PIP examination program, whose name, business address and telephone number may be obtained from the Division of Insurance.

5. PIP Examination: Any in-person physical or psychological examination, unless other review of records or evaluation is appropriate and agreed to by the parties.

B. STANDARDS AND CONDITIONS FOR MEMBERSHIP ON THE PIP EXAMINATION REVIEW PANEL

An applicant for panel membership shall complete the PIP IME registration form as required by the IME Program Administrator. By submitting a completed registration form for panel membership to the IME Program Administrator, a health care practitioner certifies he/she:

1. is qualified to serve on the panel and shall abide by all applicable statutes, rules and regulations; and

2. is actively engaged in the practice of his/her profession as defined in § 10-4-706(6)(c), C.R.S. 2002; and

3. shall personally perform a PIP examination when selected; and

4. shall promptly notify the parties to the claim of any circumstances that, in his/her judgment, constitute a conflict of interest with respect to a particular claim; and

5. shall promptly notify the IME Program Administrator of any circumstances that might disqualify the individual from panel membership in general; and

6. upon notification of being selected as an examiner for a particular claim, shall schedule the PIP examination to occur no later than fifteen (15) days from receipt of written notification, unless the parties consent to a later date; and

7. shall complete the IME report and "IME Report Summary Sheet" prescribed by the Commissioner within fifteen (15) days after the PIP examination appointment; and

8. is familiar with the provisions of § 10-4-706(6), C.R.S. 2002, and the provisions of this regulation applicable to panel members; and

9. consents to the terms and conditions set forth in § § 10-16-601 through 10-16-606, C.R.S., regardless of whether he/she is a "doctor" as defined in § 10-16-602(1), C.R.S.; and

10. shall not become a treating provider for the PIP claimant; and

11. shall perform the PIP examination in an impartial and objective manner; and

12. shall promptly respond to a request from a party to a PIP claim for copies of records from a previous PIP examination performed by such panel member regarding such claim; and

13. shall promptly notify the IME Program Administrator of any changes in information on his/her membership application, including fees.

Failure to comply with these provisions may result in removal of the panel member from membership on the PIP Examination Review Panel by the IME Program Administrator.

C. REQUESTING A PIP EXAMINATION

1. A party to a PIP claim may request a PIP examination when there is a disputed claim or when the party is dissatisfied with the findings, opinions and conclusions of a PIP review panel member. An insurer, other than an insurer using a managed care plan, shall obtain any PIP examination through the PIP examination program.

2. The requesting party shall submit a request to the IME Program Administrator on a form titled, "IME Request Form," prescribed by the Commissioner. The completed request form may be mailed or faxed to the IME Program Administrator. Concurrently, the requester shall notify the other party and the treating provider whose care is to be reviewed, of the request.

3. The requesting party shall specify the professional specialty of the health care practitioner who will perform the PIP examination. Where practical, such professional specialty shall be

the same as that of the treating health care practitioner whose treatment, opinions, diagnosis, plan of treatment, prognosis, statement of causation, or recommendations are intended to be reviewed; except that psychiatrists, psychologists, and neuropsychologists may review one another's treatment and opinions to the extent that the reviewing expert is qualified to address the specific issues which arise in a particular case.

4. In those circumstances in which several professional specialties are treating the injured party for the same injury whose treatments and opinions are sought to be reviewed in an IME, the requesting party shall designate the professional specialty of the particular health care practitioner whose treatment and opinions are intended to be reviewed.

5. In those circumstances where a PIP examination report recommends future treatment, the requesting party may designate the same PIP examiner who made such recommendations to perform a subsequent PIP examination or the requesting party may request a list of five PIP examiners as set forth in section 3.D.1.

6. An injured party under a managed care plan may request a PIP examination only after exhausting all internal grievance and review procedures available under the managed care plan. Once all internal grievance and review procedures have been exhausted, the insurer shall provide written notice to the injured party of the injured party's right to seek a PIP examination. In the event that no internal grievance and review procedures are available under the managed care plan, the injured party has the right to request a PIP examination upon denial of the claim by the insurer.

7. If an injured party who elected to receive benefits pursuant to a managed care plan chooses to be treated exclusively outside the network, the PIP benefits are no longer being provided through a managed care arrangement and the insurer is entitled to obtain a PIP IME. Treatment exclusively outside the network means treatment the injured party elects to receive outside the network, after treating both inside and outside the network for a period of time, without returning to a network provider.

D. SELECTION OF THE PANEL MEMBER AND PREPARATION OF RECORDS

1. Upon receipt of a completed “IME Request Form” , the IME Program Administrator shall prepare a list of five panel members using a revolving selection process based on the practice specialty requested and taking into account the geographical location of the claimant. Incomplete request forms may be returned to the requester by the IME Program Administrator and the selection postponed until a complete form is submitted. If the parties agree that a specific health care practitioner shall perform the PIP examination, rendering the list unnecessary, the insurer shall prepare a “Request For IME” form and a “Notice of IME” form and send them to the IME Program Administrator and the claimant. The selected health care practitioner shall be required to complete and submit the “PIP IME Report Summary Sheet” as prescribed by the Commissioner. If the injured party is residing outside the State of Colorado, the IME requester has the option to pay all reasonable expenses to bring the injured party back to the State of Colorado for the PIP examination, or. select a licensed practitioner of the same specialty as the treating practitioner if available, and agreed upon by both parties, in the state in which the injured party resides.

2. No later than five days after receipt of the completed IME Request Form, the IME Program Administrator shall transmit the list of five panel member names to the requester by mail or fax. The IME Program Administrator shall include with the list a copy of each panel member's completed information forms.

3. Within five days after receiving the list of panel member names, the requester shall strike through two names on the list and forward the list, together with the application forms

corresponding to the remaining names on the list, to the opposing party, by fax or by mail. Concurrently:

a. if the requester is the insurer, the insurer shall also send to the claimant an index of the records relevant to the disputed claim. The insurer shall denote which of the records it intends to submit to the selected panel member, listing the records in reverse chronological order (most recent first) and identifying the date and general nature of each record;

b. if the requester is the claimant, the claimant shall notify the insurer whether such claimant elects to have the insurer prepare the records file. If the claimant so elects, the insurer shall, promptly furnish the claimant with an index of the records in the insurer's file relevant to the disputed claim and the claimant shall promptly return to the insurer copies of any additional records, not already identified on the insurer's index, to be included for the PIP examination. All records identified by the insurer and any additional records identified by the claimant will be submitted to the panel member. If the claimant does not elect to have the insurer prepare the records, the claimant shall send to the insurer an index of the records he/she intends to submit for the PIP examination, listing the records in reverse chronological order and identifying the date and general nature of each record.,

c. The requester of the PIP examination shall telephone the other party to confirm the other party's actual receipt of the list and all enclosed materials.

d. All communication from the treating practitioner, the claimant, the claimant's representative, the insurer or the insurer's representative to the PIP examiner or concerning the PIP examination shall be in writing with copies sent to the other parties.

4. Within five days after actual receipt of the list of names from the requester, the other party shall strike through two of the names remaining on the list and return the list, reflecting both parties' strikes, to the IME Program Administrator and provide a copy to the requester. Concurrently:

a. If the requesting party is the insurer the claimant shall send to the requester copies of all records the claimant intends to submit to the selected panel member, that are not already identified on the requester's index of records. The claimant's records shall be in reverse chronological order to enable the requester to compile a complete file for submission to the selected panel member in accordance with section 3. E. 2. of this regulation.

b. If the requesting party is a claimant who has elected to have the insurer prepare the records, such insurer shall follow the procedures set forth in Section 3. E. 2. of this regulation for submitting the records to the selected panel member. If the requester (claimant) has not so elected, the insurer shall send to the requester copies of all records the insurer intends for submission to the selected panel member, that are not already identified on the requester's index of records. Such records shall be in reverse chronological order to enable the requester to compile a complete file for submission to the selected panel member in accordance with section 3. E. 2. of this regulation.

5. The parties shall make every effort to avoid duplication of records submitted to the selected panel member, however, the party preparing the records for submission shall not omit any record whatsoever without obtaining the written consent of the other party. Parties

may supplement the records file through the party preparing such file, but only within the time period established in section 3. E. 2. of this regulation.

6. Unless both parties agree otherwise, the failure of a party to forward the list of panel member names within that party's designated time period shall result in forfeiture of such party's right to strike names from the list. Upon being notified and confirming that such forfeiture has occurred, the IMB Program Administrator shall select-two of the remaining names on the list to be stricken.

7. To obtain a subsequent PIP examination, the party requesting the subsequent PIP examination shall follow the procedures set forth above in this regulation for requesting PIP examinations.

8. If the selected panel member knows of or becomes aware of any conflict that may prevent him/her from rendering an impartial and objective evaluation, the panel member shall notify the IMB Program Administrator and an additional name will be provided to the parties to allow the selection process to be repeated.

E. SCHEDULING THE PIP EXAMINATION AND SUBMISSION OF RECORDS

1. Upon receipt of the list indicating the name of the panel member selected, the insurer shall promptly complete the “Notice of PIP IME” as prescribed by the Commissioner and shall send the completed notice to the parties, the selected panel member, and the treating provider under review. The selected panel member shall schedule the PIP examination to occur within fifteen (15) days after actual receipt of the notice (see section 3. B. 6.), unless the parties agree to a later date, and the panel member shall notify the parties of the date, time and location of the PIP examination. If the selected panel member cannot schedule the PIP examination within fifteen (15) days and the parties cannot agree on a later date, either party may request that the selected panel member be disqualified and a new name be provided by the IME Program Administrator. A specific date shall be set, even if, by mutual agreement of the parties, only a review of records is sought. If the parties have agreed upon a health care practitioner without necessity of the list of names, the insurer shall prepare the “Request for PIP IME” and the “Notice of PIP IME” and send them to the IME Program Administrator. If the PIP examination is a reevaluation by the same PIP examiner who previously performed the PIP examination, the party requesting the reevaluation shall notify the other parties including the IME Administrator that a reevaluation is being requested with the date of the reevaluation and an index of additional records shall be provided pursuant to Section 3. D. The notification to the ME Administrator shall be made by submitting a fully completed PIP IME Request form. The provision of reevaluations by the same PIP examiner who previously performed the PIP examination shall apply to all reevaluations requested on or after the effective date of this regulation.

2. Once the PIP examination is scheduled, no later than ten (10) days prior to the date of the PIP examination, the requester or the party preparing the records (if not the requester) shall:

   a. prepare an index of the records to be affixed to the front of the records file, identifying the name of the PIP claimant, as well as the date and general nature of each record in reverse chronological order; and

   b. transmit the index of records, and the complete records file to the selected panel member; and

   c. transmit copies of the index of records to the opposing party and to the treating provider under review.

3. A PIP examination, once requested, shall not be withdrawn unless the parties agree or the disputed claim is resolved.

4. Except in cases of unforeseen or emergency events, if a claimant fails to appear for a PIP examination or does not cancel the appointment at least three (3) business days prior to the scheduled date and time of the PIP examination, the claimant shall pay a reasonable "no-show" fee, if applicable, and reschedule the PIP examination to be completed within fifteen 15 days after the initial scheduled date of the PIP examination. The selected panel member shall notify the requester that the claimant did not appear for the PIP examination and if the claimant rescheduled the examination the date of the PIP examination. If the claimant fails to reschedule the PIP examination, fails to cancel the rescheduled PIP examination at least twenty-four (24) hours in advance, or fails to appear at such examination, then (1) the PIP examiner may, at the option of the insurer, conduct the examination based on the records submitted by the parties and render an opinion based solely on the records, or (2) the insurer may deny coverage on all or part of the claim for benefits. This section is not intended to alter any terms of the contract between the insurer and insured regarding their respective rights, duties, and obligations and the law involving such matters.

F. REPORT BY PIP EXAMINER

1. No later than fifteen (15) days following the date of the PIP examination appointment, the selected panel member shall complete his/her written report and the "IME Report Summary Sheet" as prescribed by the Commissioner. The selected panel member shall transmit a copy of the completed IME Report Summary Sheet to the IME Program Administrator, and shall transmit copies of both the full report and the completed IME Report Summary Sheet to the persons identified on the Notice of PIP IME as authorized to receive the report on behalf of each party. The selected panel member is not required to send the IME report to more than two such individuals, one for the requester and one for the other party. The requester shall promptly transmit a copy of the full report and the "IME Report Summary Sheet" to the treating provider whose care was reviewed by the PIP examiner.

2. The report shall address all issues relevant to the examiner's findings with respect to the disputed claim, including, if applicable, but not limited to: reasonableness, necessity, causation, apportionment, diagnosis, prognosis, plan of treatment, need for essential services, ability to work, opinions and recommendations.

3. Questions regarding the content or completeness of the PIP examination, report and IME Report Summary Sheet shall be directed to the panel member.

Section 5 Enforcement

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of fines and/or suspension or revocation of license.

Section 6 Severability

In the event any part of this regulation is determined to be invalid for any reason, the remainder of the regulation shall not be affected thereby.

Section 7 Effective Date

This regulation is effective January 1, 2007.

Section 8 History

Originally issued as Emergency Regulation 96-E-5, effective January 1, 1997.

Emergency Regulation 97-E-2, effective April 1, 1997.

Emergency Regulation 97-E-3, effective June 30, 1997.

Regulation 5-2-9, effective September 1, 1997.

Amended Regulation 5-2-9, effective January 1, 1999.

Amended Regulation 5-2-9, effective September 1, 2000.

Amended Regulation 5-2-9, effective February 1, 2004.

Amended Regulation 5-2-9, effective January 1, 2007.

Regulation 5-2-11 Repealed Effective 06/01/2012

Regulation 5-2-12 CONCERNING AUTOMOBILE INSURANCE CONSUMER PROTECTIONS

Section 1 Authority

This Regulation is promulgated by the Commissioner of Insurance under the authority of § § 10-1-109, 10-4-601.5, 10-4-625 and 10-4-628(4), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to interpret and implement the provisions of Part 6 of Article 4 of Title 10 of the Colorado Revised Statutes. In addition, this regulation provides rules governing the rejection of coverage, cancellation, nonrenewal, increase in premium, and reduction in coverage on complying policies of automobile insurance.

Section 3 Applicability

This regulation shall apply to all insurers that issue or renew automobile coverage on or after November 1, 2012 pursuant to Part 6 of Article 4 of Title 10 of the Colorado Revised Statutes.

Section 4 Definitions

A. "Complying policy" shall have the same meaning as in § 10-4-601(2), C.R.S.

B. "Incident" shall mean an event or occurrence that results in an at-fault accident or motor vehicle conviction. An accident resulting in a motor vehicle conviction shall be treated as a single incident.

C. "Motor vehicle conviction" shall mean an adjudication of guilt to a traffic offense, whether based upon a trial resulting in conviction or a plea of guilty or no contest to the original charge or to a reduced charge.

D. "Prominently display" shall mean using bold characters, underlining, italicizing or using some other means of ensuring the information is distinct and easily recognized by the recipient of the document.

E. "Quarterly premium payment" shall mean one fourth (1/4) of the gross annual premium plus additional service charges, if any, for policies written for a term of one year or longer, or one half (1/2) of the gross six months premium, plus additional service charges, if any, for policies written for a six-month term.

F. "Usage based insurance" shall mean a rating structure that is based, in whole or in part, on the electronic accumulation of data through a device installed in a motor vehicle in which an individual's daily driving habits are used to determine a premium rate in accordance with a rating plan that has been filed with the Division.

G. "Week" shall mean any seven (7) consecutive calendar days.

Section 5 Rules

A. Installment Premium Payments.

1. Each insurer continuing private passenger motor vehicle insurance coverage shall offer, for persons who are required to purchase insurance under Part 6 of Title 10, Article 4, C.R.S., a quarterly premium payment plan. An insurer providing a plan for payments of premium on a basis that is more frequent than quarterly, need not also provide a quarterly payment plan.

2. Each insurer shall file rules, methods or procedures to provide an installment premium payment plan and payment by automatic electronic transfer in compliance with § 10-4-119, C.R.S.

3. An insurer's premium payment plan that is more frequent than quarterly may provide for payments of an advance deposit premium not greater than one month's premium.

4. Services and/or installment charges shall be based on actual expenses incurred by the insurer for billing process. Rate filings may be submitted, including a factor of increase supportive of short term billing procedures. (For example, annual premium x 26.5% = quarterly billing; or, annual premium x 9% = monthly billing.) Such charges may all be made on the first billing or distributed over each premium due date.

5. Any other payment mode, which is at least as beneficial as the quarterly payment plan referred to above, will be considered. Finance organizations, such as subsidiaries of the insurer, bank financing, or credit card services, are considered qualifying when written agreements between the insurer and the finance organization provide for installment plans to always be available to offer to the policyholders.

6. The installment premium due notice, except for monthly payments, shall be sent to the named insured and others known to the insurer as having moneys held in trust for the payment of automobile insurance premiums, at least twenty (20) calendar days prior to the actual due date. If the quarterly premium payment option is selected by an insured, each succeeding payment, after the initial premium due date, shall be at regular three-month intervals.

B. Rules Limiting Insurers' Action to Refuse to Write, Cancel, Nonrenew, Increase Premium, Surcharge or Reduce Coverages.

1. Insurers shall not refuse to write, cancel, fail to renew, reclassify an insured under, reduce coverage under, or increase the premium for any complying policy based upon:

   a. Claims paid under comprehensive coverage, unless the insurer can demonstrate that the loss was a result of an insured's actions.

   b. Claims paid under medical payments or uninsured motorist coverage.

   c. The previous producer no longer represents the company.

   d. Blindness or specific physical disability, unless such classification is based upon expected risk of loss different from that of other individuals. Further, no insurer shall refuse to insure a vehicle solely because the vehicle is owned by a blind person.

   e. Motor vehicle citations without convictions.

2. Insurers shall not increase premium, other than a general increase filed with the Commissioner of Insurance, or refuse to renew a complying policy based upon:

   a. Payments made by insurers, without a good faith reasonable investigation to determine fault, unless the insured has admitted the reported accident was his or her fault and the evidence of admission of fault is provided. A reasonable fault investigation to support the insurer's intended action shall include, at a minimum, when available:

      (1) Statements (oral, telephonic recordings or written) from all parties involved in the accident and all known eyewitnesses. A statement shall be deemed unavailable when the insured, other party in the accident or eyewitness refuses to give or sign the statement.

      (2) Copies of all loss, accident, and police reports.

   b. The use of a single accident resulting in payment of less than $1,000, unless the insurer has elected to file with the Division of Insurance a rating plan such as a Safe Driver Plan, an Accident Surcharge Plan, etc., which includes statistical data justifying the use of a lesser threshold.

c. The use of an individual's driving and/or loss record, while a resident of the household, if a driver exclusion offer has been made and the driver is excluded from coverage in compliance with § 10-4-630, C.R.S.

d. Existence of a physical impairment, unless the impairment is of a continuing nature, which has an adverse effect on the insured's ability to drive safely, and cannot be corrected by the use of medication or special equipment. In the event of a complaint by the insured, the insured shall have the burden of proving that the impairment does not have an adverse effect on the insured's ability to drive safely.

e. Claims paid under towing and labor coverage.

3. Insurers shall not refuse to renew a complying policy based upon:

a. The use of one (1) motor vehicle conviction resulting in less than eight (8) points assessed under the Colorado Motor Vehicle Point Assessment system or points assessed by another state.

b. The use of one (1) motor vehicle accident, whether or not payment is made, unless a motor vehicle conviction of eight (8) points or more, assessed under the Colorado motor vehicle point assessment system, or points assessed by another state, resulted from the accident.

As used in this subsection, a conviction, accident, or payment made for the same occurrence shall be considered as one incident.

4. In reviewing complaints of intended action under a complying policy the Division of Insurance will apply the following time limitations:

a. If the insurer bases its action upon the fact that an insured has had an incident that resulted in payment under the policy and/or a motor vehicle conviction, the insurer may base its action on incidents that occurred during the thirty-six (36) month period immediately preceding the date of the intended action for that individual insured under the policy. However, in case of nonrenewals, increase in premiums, or reduction in coverage, in order to take action upon incidents occurring during this thirty-six (36) month period, at least one (1) incident must have occurred during the fifteen (15) month period immediately preceding the next renewal date for each individual upon whom the intended action is being attempted. Cancellations are subject to the restrictions set forth in § 10-4-602, C.R.S.

b. An insurer may exceed the fifteen (15) month period if such renewal is the first opportunity to underwrite an additional insured, i.e., new driver in household. The notice shall clearly indicate the date the individual was added to the policy and whether this renewal is the first opportunity to underwrite the risk. Surcharge or merit rating changes may only be made on the policy renewal date.

c. An insurer may cancel a newly issued policy that has been in effect less than sixty (60) calendar days at the time notice of cancellation is sent by the insurer. Any such notice of cancellation may not be based on any of the prohibited reasons listed in § § 10-4-626, 10-4-627, 10-4-628 and 10-4-629, C.R.S.

(1) Notice requirements for such cancellations are governed by policy termination provisions. The notice shall be mailed at least ten (10) calendar days prior to the cancellation effective date.

(2) Whenever the insurer chooses to cancel a policy, the earned premium shall be determined on a pro-rata basis, including cancellation for nonpayment of premium.

d. An insurer may not rescind (i.e., cancel retroactively) a policy of insurance affording the coverages required by § § 10-4-609, 10-4-620, and 10-4-621, C.R.S., or void such coverage, except in case of fraud, as defined in § 10-1-128, C.R.S., or if the insurer does not receive appropriate premium payment (i.e. insufficient funds) for the policy at the time of application.

5. Notice of intended actions.

a. A notice to cancel, nonrenew, increase the premium or reduce coverage under a private passenger motor vehicle insurance policy shall state the actual reason for such action. The notice required by § 10-4-629(2), C.R.S. shall be distinct from any other information delivered to the insured, but may be sent with other insurance documents. The notice shall include a statement of reasons that are clear and specific so that a reasonable person can understand the reasons without making further inquiry. The insurer shall clearly describe or quote its underwriting rule, policy or guideline that is the basis for the intended action. A simple recitation of dates and incidents, without specific detail, is not acceptable.

b. Insurers intending to cancel, nonrenew, increase premium or reduce coverage shall prominently display the insured's right to submit a complaint to the Division of Insurance and the following information on the notice form:

If you have concerns regarding this intended action, you have the right to file a complaint with the Colorado Division of Insurance. Complaints may be submitted through the mail or electronically. Please contact [your producer, (agent) or the company at (phone number)], for further information.

c. The fact that an insured has submitted a complaint shall not negate the insurer's obligation under § § 10-4-629(2) and 10-4-630, C.R.S., to offer the insured the right to exclude a household member.

d. For the purposes of this Section 5.B.5., a notice of intended action is not required if the increase in premium is strictly the result of an insured's voluntary enrollment in a usage based insurance rating program. If an increase in premium is the result of a combination of usage based insurance rating and any adverse activity that is otherwise subject to this regulation, a notice of intended action is required.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition

of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 8 Effective Date

This regulation is effective November 1, 2012.

Section 9 History

Originally issued effective February 1, 2004.

Amended regulation effective December 1, 2004.

Amended regulation effective January 1, 2007.

Amended regulation effective August 1, 2007.

Amended regulation effective September 1, 2009.

Amended regulation effective January 1, 2011.

Repealed and repromulgated effective November 1, 2012.

Regulation 5-2-13 Repealed Effective 06/01/2012

Regulation 5-2-14 [Reserved]

Regulation 5-2-15 CONCERNING CONSUMER PROTECTION FOR VEHICLE VALUATION AND RENTAL REIMBURSEMENT

Section 1 Authority

This regulation is promulgated under the authority of § § 10-1-109, 10-3-1110 (2), 10-4-601.5 and 10-4-639 (3) (4), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish standards for payment of claims for vehicle rental and collision damage waivers, and for valuation of total loss claims under private passenger auto insurance policies.

Section 3 Applicability

This regulation shall apply to all insurers that provide automobile insurance policies.

Section 4 Definitions

A. "Total Loss" means the condition of a motor vehicle when it is damaged or destroyed to such an extent that the insurer determines it cannot be rebuilt or repaired to its condition prior to the loss; or the cost of the loss (including, but not limited to, rental expenses, specialized labor and part availability) make the repairs of the vehicle uneconomical.

B. "Valuation" means the method of determining the worth of property that has been lost or damaged.

C. "Third-Party Claimant" means the individual other than the insured or the insurer who has incurred a loss or is entitled to receive a benefit payment as a result of the negligent acts or omissions of the insured.

D. "Collision Damage Waiver" means the special property damage coverage purchased by an individual renting an automobile under which the rental company waives any right to recover property damage to the automobile from that individual regardless who is at fault.

Section 5 Rules

A. Total Loss Claims

1. The insurer shall develop and maintain written procedures that will be consistently used when determining the value of a vehicle declared a total loss.

2. Claims files shall include the credible source used for valuation by vendor name and the methodology for determining the amount of the loss. Claims files shall document that the valuation considered unique characteristics of a total loss vehicle, such as classic status, unique finishes, mileage and/or, special accessories.

B. Payment For Temporary Replacement of Damaged Motor Vehicles

1. An insurer shall provide payment to a third-party claimant for a collision damage waiver required by a motor vehicle rental company when the claimant does not have collision coverage, or coverage does not extend to a rental vehicle through his or her own motor vehicle insurance and the insurer may request the following:

   a. Verification that the claimant did not have collision coverage on the damaged vehicle, at the time of loss, or that the collision coverage on his/her automobile policy does not extend to rental vehicles; and

   b. Verification that the Collision Damage Waiver was signed, by the claimant, indicating collision coverage was secured.

2. Payments for third-party coverage for a replacement motor vehicle, of a comparable class, shall not be discontinued until:

a. Three days after payment for the total loss of the motor vehicle was mailed, via US Postal Service, to the last-known address of the claimant or after a reasonable settlement offer has been made in compliance with § 10-3-1104 (1) (h), C.R.S.; or

b. One day after payment for the total loss of the motor vehicle was transmitted via overnight delivery to the last-known address of the claimant or directly to the financial account of the claimant; or

c. Payment is made directly to the entity repairing the motor vehicle of the claimant and the repaired vehicle is returned to the claimant or claimant has a reasonable opportunity to take possession of the vehicle from the repair facility.

3. An insurer shall not be required to pay for a replacement motor vehicle or any portion of such expense directly related to delays by the claimant or delays by a repair facility selected by the claimant.

C. Failure to comply with this regulation constitutes an unfair or deceptive act or practice in the business of insurance.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 8 Effective Date

This regulation shall become effective on August 1, 2012.

Section 9 History

New regulation issued effective December 1, 2004.

Amended regulation effective August 1, 2012.

Regulation 5-2-16 DISCLOSURE REQUIREMENTS FOR PRIVATE PASSENGER AUTOMOBILE POLICIES

Section 1 Authority

Section 2 Scope and Purpose

Section 3 Applicability

Section 4 Definitions

Section 5 Rules

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § § 10 1 109, 10-4-111(5), 10-4-601.5, 10-4-636, and 10-4-641(1) C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to interpret and implement the provisions of § § 10 4 111 (1) and (5) and 10-4-636, of the Colorado Revised Statutes, to provide summary disclosure requirements and the summary disclosure form for private passenger automobile insurance.

Section 3 Applicability

This regulation shall apply to all licensed insurers or producers in Colorado issuing private passenger automobile policies pursuant to Part 6 of Article 4 of Title 10 of the Colorado Revised Statutes.

Section 4 Definitions

A. "Adequate Evidence" shall have the same meaning as set forth in § 10-4-636(3)(b), C.R.S.

B. "Automobile" for the purposes of this regulation and summary disclosure shall include motor vehicles, low-power scooters, and motorcycles as defined in § § 10-4-601 (6) and 42-1-102 (48.5) and (55), C.R.S.

C. "Commercial Automobile Insurance Policy" means any policy issued pursuant to the requirements of § § 10-4-1401 et seq., C.R.S., where the organization or entity qualifies as an exempt commercial policyholder and the requirements outlined in the foregoing statute and Division Regulation 5-1-13 have been met.

D. "Initial Insurance Purchase" means when the application for insurance is submitted and payment is made to the insurer or producer.

E. "Optional or Enhanced Coverages" means those coverages that will result in an increased premium to an insured’s policy, and for which the express consent of the insured is required, but does not include uninsured or underinsured motorist coverage or medical payments coverage.

F. "Summary Disclosure Form" means the form that contains an explanation of the major coverages and exclusions of an insurer’s automobile insurance policy, together with a recitation of general factors considered in cancellation, nonrenewal and increase-in-premium situations.

Section 5 Rules

A. Summary Disclosure Form

1. The summary disclosure form shall provide notice in bold face letters that the policyholder should read the policy for complete details and that such summary disclosure form shall not be construed to replace any provision of the policy itself.

2. Insurers and producers shall use the attached summary disclosure form as outlined in Section 5(B). Insurers and producers shall not modify this form except to provide additional or more specific information. Insurers shall place this form on file with the Colorado Division of Insurance (Division) for public inspection.

3. Every insurer shall update and file with the Division the summary disclosure form periodically to reflect changes in major coverages and exclusions of such policies of insurance and changes in factors considered in cancellation, nonrenewal and increase-in-premium situations.

B. Disclosure Requirements

1. A licensed insurer or producer writing automobile insurance coverage must provide the summary disclosure form to applicants for insurance coverage, at the time of the initial insurance purchase and thereafter on any renewal when there are changes in major coverages and exclusions or changes in factors considered in cancellation, nonrenewal and increase-in-premium situations.

2. The summary disclosure form must be delivered to the applicant at the time of the initial insurance purchase (or renewal when applicable). Such delivery may be made in the following manner: through the insurer or producer's internet web site; by hand-delivery, facsimile or e-mail to the applicant; or if none of the foregoing modes of delivery are available, by placing a copy of the form in the mail to the applicant within 48 hours of purchase.

3. The summary disclosure form is a required form. If there is a dispute after inception of the policy regarding whether the summary disclosure form was provided at the time of the initial purchase of the policy (or renewal when applicable), the insurer or producer must be able to provide evidence that the summary disclosure form was provided to the applicant or insured, otherwise the presumption will be that the summary disclosure form was not provided to the applicant or insured.

4. The explanation of medical payments coverage is required in the summary disclosure form. The insurer must issue policies with $5000 medical payments coverage unless its insured rejects such coverage in writing or in the same medium in which the application for the policy was taken. Nothing in this section shall prohibit the insurer from offering higher medical payments limits.

5. The disclosure requirements outlined in this Regulation do not apply to policies insuring exempt commercial policyholders as defined in § § 10 4 1401, et seq., C.R.S.

6. The disclosure requirements outlined in this Regulation apply to automobiles as defined in Section 4.B of this regulation.

C. Additional Disclosure Requirements

1. An insurer must provide a clear explanation to the insured regarding:

   a. The products purchased;

   b. The amount of coverage purchased; and

   c. How the determination of fault in an automobile accident affects the applicability of coverage.

2. The additional disclosure requirements outlined in Section 5.C.1. a and b above may be satisfied by including the information in the Declarations page of the policy.

3. The additional disclosure requirement outlined in Section 5.C.1.c above shall be satisfied through the issuance of the summary disclosure form referenced in Section 5.A. of this regulation.

D. Optional and Enhanced Coverages

1. An insurer or producer shall not automatically add optional or enhanced coverages that will result in an increased premium to an insured's policy without the express consent of the insured.

2. The consent of the insured may be provided in the same medium in which the policy is offered. The insurer or producer shall maintain adequate evidence of the insured's consent for at least three years. Such evidence shall be subject to review by the commissioner.

3. An insurer or producer must record whether the optional or enhanced coverage added for an increased premium was requested by the insured or recommended by the insurer or producer and consented to by the insured.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Enforcement

Noncompliance with this Regulation may result, after proper notice and hearing, in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of fines, issuance of cease and desist orders, and/or suspensions or revocation of license. Among others, the penalties provided for in §10-3-1101 et seq., C.R.S. may be applied.

Section 8 Effective Date

This regulation shall become effective January 1, 2012.

Section 9 History

New regulation effective January 1, 2007.

Amended regulation effective January 1, 2008.

Amended regulation effective January 1, 2009.

Amended regulation effective January 1, 2012

COLORADO PRIVATE PASSENGER AUTOMOBILE INSURANCE - SUMMARY DISCLOSURE FORM

This summary disclosure form is a basic guide to the major coverages and exclusions in your policy. It is a general description. It is not a policy of any kind. All coverage is subject to the terms, conditions, and exclusions of your policy and all applicable endorsements.

PLEASE READ YOUR POLICY FOR COMPLETE DETAILS. THIS SUMMARY DISCLOSURE FORM SHALL NOT BE CONSTRUED TO REPLACE ANY PROVISION OF THE POLICY ITSELF.

Complete details include, but are not limited to, information on the method we use to calculate your unearned premium (e.g., pro rata or short rate), if you should cancel your policy before the next renewal. This summary disclosure form also provides some of the factors considered for cancellation, nonrenewal and increase-in-premium. These factors are general in nature. They do not represent the only reasons a policy may be cancelled or changed. Please contact us or your agent for further information.

I. REQUIRED COVERAGE - Liability

Colorado law requires you to have liability coverage on your automobile. This coverage pays bodily injury to another person and property damage to another's property that are the result of an accident in which you are found to be at fault.

Coverage is not provided for any automobile owned by you or a resident relative that is not insured for liability under your policy. There is no coverage for intentional acts.

Please read your policy for other conditions and exclusions.

II. OTHER COVERAGES

A. Uninsured and Underinsured Motorist Coverage

Uninsured and underinsured motorist coverage will be included in your policy unless you reject it in writing.

Uninsured Motorist coverage pays for your bodily injury damages that are the result of a not at fault accident with an uninsured or hit and run driver.

Underinsured Motorist coverage pays for your bodily injury damages that are the result of a not at fault accident with an underinsured driver. A motorist is considered underinsured if his or her liability coverage is not enough to pay the full amount you are legally allowed to recover as damages.

Please read your policy for other conditions and exclusions.

B. Physical Damage Coverage – Collision and Comprehensive

You must be offered collision coverage.

Collision coverage pays for damage to your own automobile when it collides with another automobile or object. It also pays if your automobile overturns.

Comprehensive coverage pays for damage to your automobile from causes such as fire, theft, vandalism, hail, and falling objects.

Collision and comprehensive coverage may be written with a deductible. A deductible is that part of a loss you will pay. We will pay the balance of covered repairs subject to your policy provisions. A lender may require you purchase both collision and comprehensive coverage.

Coverage does not apply to losses that occur while your automobile is rented or leased to others. There is no coverage for wear, tear, freezing, mechanical failure or breakdown, or road damage to tires.

Please read your policy for other conditions and exclusions.

C. Medical Payments Coverage

Medical payments coverage of $5,000 will be included in your policy unless you reject it. You may reject the coverage in writing or in the same method in which you applied for the policy.

Medical payments coverage is not required to be offered on motorcycles, low-power scooters, off-road vehicles or other miscellaneous vehicles.

Medical payments coverage pays for you and your passengers reasonable health care expenses incurred for bodily injury caused by an automobile accident.

If you are in an automobile accident, your medical payments coverage will pay before your health insurance coverage.

Medical payments coverage will apply toward health coverage coinsurance or deductible amounts.

We must prioritize the payment of your benefits in a manner consistent with Colorado insurance law.

Injuries to you that are the result of an at-fault accident will not be paid, under an automobile insurance policy, unless medical payments coverage is purchased.

Please read your policy for other conditions and exclusions.

D. Uninsured Motorist Property Damage Coverage

This coverage pays for damages to your automobile caused by an at-fault owner of an uninsured automobile.

This is an optional coverage you can request if you do not have collision coverage on your automobile.

This coverage will not apply if the automobiles do not make physical contact.

This coverage only pays actual cash value of your automobile or cost of repair or replacement, whichever is less.

Please read your policy for other conditions and exclusions.

III. CANCELLATION, NONRENEWAL AND INCREASE IN PREMIUM

A. Cancellation

During the first 59 days we may cancel your policy for any reason not prohibited by law. After your policy has been in effect for more than 59 days, we may cancel your policy for any of the following reasons:

1. Nonpayment of policy premium; or

2. Knowingly making a false statement on your application for automobile insurance; or

3. A driver's license suspension or revocation; or

4. Knowingly and willfully making a false material statement on a claim under the policy.

B. Nonrenewal

We may choose to non-renew your policy. Some examples of reasons for nonrenewal include, but are not limited to:

1. An unacceptable number of traffic convictions;

2. An unacceptable number of at-fault accidents; or

3. Conviction of a major violation such as drunk driving or reckless driving.

C. Increase in Premium

We may increase your premiums for the following reasons:

1. Change of garage location of the automobile;

2. Change of automobile(s) insured;

3. Addition of a driver;

4. Change in use of your automobile;

5. A general rate increase. This results from the loss experience of a large group of policyholders rather than from a single policyholder. A general rate increase applies to everyone in the group, not just those who had a loss.

The above list of reasons is not all inclusive. There may be other changes that result in an increased premium.

We may add a surcharge or remove an accident free discount because of an at-fault accident or traffic conviction. Under this circumstance you will receive a statutory right to protest this action.

Regulation 5-3-1 WORKERS COMPENSATION RISK MANAGEMENT REGULATION

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of Sections 10-1-109 and 10-4-408, C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to provide standards for risk management programs and services required to be offered by workers compensation insurers, licensed to conduct business in this state, including Pinnacol Assurance.

Section 3 Applicability

This regulation shall apply to all insurers authorized to issue worker's compensation insurance policies in Colorado including Pinnacol Assurance.

Section 4 Definitions

A. "Anniversary date" means the annual anniversary of the date of issue of a workers compensation insurance policy as shown in the policy declaration.

B. "Certified workers compensation risk management program or service" means a program or service which meets the minimum standards of this regulation and is certified by the Colorado Cost Containment Board located at the Colorado Division of Labor and Employment.

C. "Initial certification date" means the date the risk management program of a business entity is initially certified by the Colorado Cost Containment Board. A risk management program that meets the risk management standards of this regulation will be initially certified one year after the implementation of the program by the business entity.

D. "Re-certification date" means each annual anniversary date of the initial certification.

E. "Risk management" means the process that uses physical and human resources to prevent or reduce losses.

F. "Risk management service" means such activities as loss exposure identification, determination of the size of exposure and the degree of hazard, loss control services, and management services.

Section 5 Rules

A. Minimum Risk Management Standards

A risk management program must comply with the following standards:

1. Designated Medical Provider

    a. Employers will designate a medical provider in writing, who:

        (1) Has a knowledge of work injuries;

        (2) Is knowledgeable of fee schedules;

        (3) Is decisive on medical-maximum-improvement determinations;

        (4) Communicates with the employer on such issues as case management and wellness programs;

        (5) Is knowledgeable of the employers operations.

    b. The name of the provider must be posted and well publicized by the employer.

2. A safety coordinator must be appointed by the employer to:

    a. Discuss/recommend safety policies;

    b. Identify unsafe conditions and practices;

    c. Investigate and report accidents;

    d. Conduct safety drives.

3. Employers must institute loss prevention rules which are:

a. Clearly defined.

b. Posted in conspicuous areas located throughout the workplace.

4. Employers must have a declaration of risk management policy. This statement should contain the following information:

   a. The safety and health of employees and the public are of chief importance;

   b. The prevention of accidents is more important than speed or short cuts.

   c. Every attempt should be made to reduce the possibility of an accident occurring;

   d. Management sign off on the risk management policy;

   e. An outline of the responsibilities of employer and employees. All risk management programs must have a designated representative and should have an employee orientation.

5. A loss prevention training program must be established and conducted which involves:

   a. Thorough job/task training;

   b. Employee sign-off on training;

   c. Measures and controls for job safety;

   d. On-going job/task training;

   e. Training to be conducted by management, trainer or supervisor;

   f. Training of key people;

   g. The proper use of safety equipment, methods and wear of safety equipment.

6. Employers will implement policies and procedures which:

   a. Explain benefits to the injured employee;

   b. Assure that the insurance company is contacted in a timely manner;

   c. Investigate the accident;

   d. Initiate an early back to work program, when possible;

   e. Never commit to benefits; merely report the accident to the insurance company;

   f. Confirm that the employee was working at the time of the accident/injury;

   g. Determine the cause of the accident and develop controls for prevention;

   h. Provide for a modified work plan, when feasible;

   i. Show concern for injured employees;

j. Reassure injured employees' financial concerns.

B. Risk Management Services

All workers compensation insurers and Pinnacol Assurance are required to provide risk management services which include identifying loss exposures, measuring the size of the exposures and in determining varying degrees in hazards. Furthermore, insurers are to assist insured business entities in selecting techniques to handle exposures, and in establishing and implementing a risk management program which meets the minimum standards of this Regulation.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Enforcement

Non compliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance or other laws which include the imposition of fines and/or suspension or revocation of license.

Section 8 Effective Date

This regulation is effective June 1, 2012.

Section 9 History

Issued as new regulation 91-5, effective May 1, 1991

Re-codified as regulation 5-3-1, effective June 1, 1992

Amended regulation 5-3-1, effective March 2, 2003

Amended regulation 5-3-1, effective June 1, 2012

Regulation 5-3-2 Repealed Effective 12/01/2012.

Regulation 5-3-3 CONCERNING WORKERS' COMPENSATION LARGE DEDUCTIBLE POLICIES

Section 9 History

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § 10-1-109(1) and (2), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to promulgate rules for payments to the Major Medical Insurance Fund created in § 8-46-202, C.R.S., the Subsequent Injury Fund created in § 8-46-101, C.R.S., the Workers' Compensation Cash Fund created in § 8-44-112 (7), C.R.S., and the Cost Containment Fund created in § 8-14.5-108, C.R.S., on workers' compensation insurance deductible policies in excess of the limit set forth in § 8-44-111(1), C.R.S., and to clarify the liability of insurers to employees under insurance contracts.

Section 3 Applicability

This regulation shall apply to all insurers authorized to issue worker's compensation insurance policies in Colorado including Pinnacol Assurance.

Section 4 Definitions

"Large deductible policy" means a policy subject to a deductible in excess of the "split point" filed by a rating organization and approved by the Commissioner of Insurance.

"Split point" shall have the same meaning as defined in § 8-44-111 (1) (b), C.R.S.

Section 5 Rules

A. Pursuant to § 8-44-105, C.R.S., every large deductible policy shall contain a provision stating that the insurer is liable to pay workers' compensation benefits directly to the employee or the employee's dependents, in the event of death. All other provisions in § 8-44-105, C.R.S., are applicable to large deductible policies.

B. The premium reported to the Colorado Division of Workers' Compensation is subject to assessment by the Major Medical Insurance Fund, the Subsequent Injury Fund, the Workers' Compensation Cash Fund and the Cost Containment Fund.

C. The premium for large deductible policies shall be subject to the same reporting requirements as other workers' compensation premiums subject to assessment as stated in 5.B. Every workers' compensation insurer authorized to conduct business in Colorado, including Pinnacol Assurance, shall report large deductible policy premiums to the Colorado Division of Workers' Compensation as: if the policy had no deductible, and after application of any credits or debits for experience rating, schedule rating, premium size, risk management, or employer designated medical provider.

D. The requirements of this regulation apply to all large deductible policies issued or renewed after the effective date of this regulation.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 8 Effective Date

This regulation is effective January 1, 2014.

Section 9 History

New Regulation 5-3-3, effective January 1, 1995

Emergency Regulation 98-E-1, effective July 1, 1998

Amended regulation 5-3-3, effective September 28, 1998

Amended regulation 5-3-3, effective March 2, 2003

Amended regulation 5-3-3, effective June 1, 2012

Amended regulation 5-3-3, effective October 1, 2013

Amended regulation 5-3-3, effective January 1, 2014

Regulation 5-3-4 CONCERNING STANDARDS FOR NOT AT-FAULT MOTOR VEHICLE ACCIDENTS UNDER WORKERS' COMPENSATION, LOSS LIMITATION IN CALCULATING EXPERIENCE MODIFICATIONS AND DISTRIBUTION OF LOSSES IN EXCESS OF THE LOSS LIMITATION

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § § 10-1-109 and 10-4-408(5)(e), C.R.S.

Section 2 Scope and Purpose

The purpose of this regulation is to establish and implement final rules that provide standards for determining when a motor vehicle accident is not at fault, a loss limitation to be included in the calculation of workers' compensation insurance experience modifications, the loss distribution among workers' compensation classifications of any loss in excess of the loss limitation, when the use of a motor vehicle is an integral part of an employer's business.

Section 3 Applicability

This regulation shall apply to all insurers authorized to issue worker's compensation insurance policies in Colorado including Pinnacol Assurance.

Section 4 Rules

A. Not At-Fault Motor Vehicle Accidents

Not at-fault motor vehicle accidents shall be accidents occurring under the following circumstances:

1. The operator of the other vehicle involved in the accident has been found liable or has admitted liability for the accident.

2. The motor vehicle operated by the employee or the employer of the employee was struck in the rear by another vehicle and the employee or the employer of the employee has not been convicted of a moving traffic violation in connection with the accident;

3. The operator of the other motor vehicle involved in the accident was convicted of a moving traffic violation and the employee or the employer of the employee has not been convicted of a moving traffic violation in connection with the accident; or

4. The motor vehicle operated by the employee or the employer of the employee was struck by a "hit-and-run" motor vehicle.

B. Loss Limitation

If an employer qualifies for an experience modification, the calculation of such experience modification shall not include any loss in excess of $2,000 per accident as a result of a motor vehicle accident in which the employee or the employer of the employee was not at fault and the use of the motor vehicle is not an integral part of the employers business.

C. Distribution of Loss in Excess of Loss Limitation

1. Any loss remaining in excess of the $2,000 loss limitation shall be distributed among all workers' compensation classifications. Such distribution shall be reflected in the loss costs or rates made by workers' compensation insurers, including Pinnacol Assurance and rating/advisory organizations and shall be stated as a surcharge factor of the manual classification rates.

2. All insurers, including Pinnacol Assurance, shall annually notify all policyholders who qualify for an experience modification of the number of motor vehicle accidents which have met the $2,000 loss limitation. Such notification shall indicate that the amount in excess of the $2,000 limitation has been distributed among all classifications.

D. Employers Affected by Loss Limitation

Experience modifications of employers who use motor vehicles as an integral part of their business should not be affected by the $2,000 loss limitation. Motor vehicle use should be considered an integral

part of the business when the use of a motor vehicle is the primary means of the employer's operations to transport goods and people.

Section 5 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 6 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 7 Effective Date

This regulation is effective July 1, 2012.

Section 8 History

New Regulation 5-3-4, effective February 1, 1995.

Amended regulation, effective March 2, 2003.

Amended regulation 5-3-4, effective July 1, 2012.

Regulation 5-3-5 WORKERS' COMPENSATION DEDUCTIBLE REIMBURSEMENT

Section 1 Authority

This regulation is promulgated and adopted by the Commissioner of Insurance under the authority of § § 8-44-111 and 10-1-109, C.R.S.

Section 2 Scope and Purpose

Pursuant to § 8-44-111(3), C.R.S., Colorado is a net reporting state for workers' compensation insurance. This means that an employer's deductible up to the split point is subtracted from the amount of the loss per claim for the purpose of calculating the employer's experience modification factor. Many employers have not received the intended benefit of the deductible exclusion. Due to reporting requirements, insurers reported the full loss to the statistical agent because they had not actually received the deductible reimbursement from the employer. Frequently, insurers fail to correct their unit statistical reports to show the paid deductible amount, thereby depriving the employer of the benefit of the deduction. This rule eliminates the requirement of actual receipt of the deductible by insurers prior to reporting such deductible to the statistical agent for the purpose of calculating the experience modification factor.

Section 3 Applicability

This regulation shall apply to all insurers authorized to issue workers' compensation insurance policies in Colorado including the Colorado Compensation Insurance Authority also known as Pinnacol Assurance who issue policies with a deductible.

Section 4 Definition

"Split point" shall have the same meaning as defined in § 8-44-111 (1) (b), C.R.S.

Section 5 Rule

Workers' Compensation insurers writing deductible insurance policies in Colorado are required to deduct the full amount of the policy deductible from any claim reported, up to the "split point" filed by a rating organization and approved by the Commissioner of Insurance for each claim. This shall be applicable for large and small deductible programs, without regard to the actual receipt of the deductible when initially reporting a loss to any statistical agent for the calculation of the employers experience modification factor. Elimination of the actual receipt requirement will ensure that more employers receive accurate experience modification factors.

However, insurers shall also report the total or full amount of the loss (without regard to the split point exclusion above). This is to ensure that the full amount of the loss is reported properly for purposes other than calculating the experience modification factor.

Section 6 Severability

If any provision of this regulation or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of this regulation shall not be affected.

Section 7 Enforcement

Noncompliance with this regulation may result in the imposition of any of the sanctions made available in the Colorado statutes pertaining to the business of insurance, or other laws, which include the imposition of civil penalties, issuance of cease and desist orders, and/or suspensions or revocation of license, subject to the requirements of due process.

Section 8 Effective Date

This regulation is effective January 1, 2014.

Section 9 History

New Regulation 5-3-5, effective July 1, 2002.

Amended Regulation 5-3-5, effective July 1, 2012.

Amended Regulation 5-3-5, effective October 1, 2013.

Amended Regulation 5-3-5, effective January 1, 2014.

Editor's Notes

History

Regulation 5-2-3, Regulation 5-2-12 eff. 07/30/2007.

Regulation 5-2-16 eff. 07/01/2008.

Regulations 5-2-11 and 5-2-16 eff. 01/01/2009.

Regulation 5-1-10 eff. 08/01/2009.

Regulation 5-2-12 eff. 09/01/2009.

Regulation 5-2-12 eff. 01/01/2011.

Regulation 5-1-1 eff. 07/15/2011.

Regulation 5.2.16 eff. 01/01/2012.

Regulations 5-1-1, 5-1-11, 5-1-12, 5-3-1, 5-3-3 eff. 06/01/2012; Repealed 5-2-1, 5-2-3, 5-2-5, 5-2-6, 5-2-7, 5-2-11, 5-2-13 eff. 06/01/2012.

Regulations 5-1-2, 5-1-8, 5-2-2, 5-3-4, 5-3-5 eff. 07/01/2012.

Regulations 5-1-9, 5-1-15, 5-2-15 eff. 08/01/2012.

Regulation 12-E-12 emer. rule eff. 08/08/2012.

Regulations 5-1-6, 5-1-14, 5-1-17, 5-2-8 eff. 09/01/2012.

Regulation 5-1-10 eff. 10/01/2012.

Regulations 5-1-13, 5-2-12 eff. 11/01/2012.

Regulation 5-3-2 repealed eff. 12/01/2012.

Regulation 5-1-12 eff. 04/01/2013.

Regulation E-13-04 emer. rule eff. 06/18/2013.

Regulations 5-1-18, 5-3-3, 5-3-5 eff. 10/01/2013.

Regulation 13-E-14 emer. rule eff. 10/25/2013.

Regulations 5-3-3, 5-3-5 eff. 01/01/2014.

Regulation 5-1-19 eff. 02/14/2014.

Annotations

Unless modified, corrected or vacated, the decision of the arbitrators shall be final. The final award may be confirmed and converted to a judgment. *Dale v. Guaranty Nat. Ins. Co.,* 948 P.2d 545 (1997).

Trial court improperly relied on 3 C.C.R. § 702-5 in summary judgment that found that plaintiff could not prevail on their claim as a matter of law. *Reyer v. State Farm Mut. Auto. Ins. Co. , Colo. App. 06CA 0239 (2007).*