Sec. 38a-816. (Formerly Sec. 38-61). Unfair practices defined. The following are defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

(1) Misrepresentations and false advertising of insurance policies. Making, issuing or circulating, or causing to be made, issued or circulated, any estimate, illustration, circular or statement, sales presentation, omission or comparison which: (A) Misrepresents the benefits, advantages, conditions or terms of any insurance policy; (B) misrepresents the dividends or share of the surplus to be received, on any insurance policy; (C) makes any false or misleading statements as to the dividends or share of surplus previously paid on any insurance policy; (D) is misleading or is a misrepresentation as to the financial condition of any person, or as to the legal reserve system upon which any life insurer operates; (E) uses any name or title of any insurance policy or class of insurance policies misrepresenting the true nature thereof; (F) is a misrepresentation, including, but not limited to, an intentional misquote of a premium rate, for the purpose of inducing or tending to induce to the purchase, lapse, forfeiture, exchange, conversion or surrender of any insurance policy; (G) is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any insurance policy; or (H) misrepresents any insurance policy as being shares of stock.

(2) False information and advertising generally. Making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading.

(3) Defamation. Making, publishing, disseminating or circulating, directly or indirectly, or aiding, abetting or encouraging the making, publishing, disseminating or circulating of, any oral or written statement or any pamphlet, circular, article or literature which is false or maliciously critical of or derogatory to the financial condition of an insurer, and which is calculated to injure any person engaged in the business of insurance.

(4) Boycott, coercion and intimidation. Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.

(5) False financial statements. Filing with any supervisory or other public official, or making, publishing, disseminating, circulating or delivering to any person, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated or delivered to any person, or placed before the public, any false statement of financial condition of an insurer with intent to deceive; or making any false entry in any book, report or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to whom such insurer is required by law to report, or who has authority by law to examine into its condition or into any of its affairs, or, with like intent, wilfully omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report or statement of such insurer.

(6) Unfair claim settlement practices. Committing or performing with such frequency as to indicate a general business practice any of the following: (A) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue; (B) failing to acknowledge and act with reasonable promptness upon communications with respect to claims arising under insurance policies; (C) failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies; (D) refusing to pay claims without conducting a reasonable investigation based upon all available information; (E) failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed; (F) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear; (G) compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds; (H) attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application; (I) attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of the insured; (J) making claims payments to insureds or beneficiaries not accompanied by statements setting forth the coverage under which the payments are being made; (K) making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration; (L) delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information; (M) failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage; (N) failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or

applicable law for denial of a claim or for the offer of a compromise settlement; (O) using as a basis for cash settlement with a first party automobile insurance claimant an amount which is less than the amount which the insurer would pay if repairs were made unless such amount is agreed to by the insured or provided for by the insurance policy.

(7) Failure to maintain complaint handling procedures. Failure of any person to maintain complete record of all the complaints which it has received since the date of its last examination. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints, and the time it took to process each complaint. For purposes of this subsection "complaint" means any written communication primarily expressing a grievance.

(8) Misrepresentation in insurance applications. Making false or fraudulent statements or representations on or relative to an application for an insurance policy for the purpose of obtaining a fee, commission, money or other benefit from any insurer, producer or individual.

(9) Any violation of any one of sections 38a-358, 38a-446, 38a-447, 38a-488, 38a-825, 38a-826, 38a-828 and 38a-829. None of the following practices shall be considered discrimination within the meaning of section 38a-446 or 38a-488 or a rebate within the meaning of section 38a-825: (A) Paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders; (B) in the case of policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expense; (C) readjustment of the rate of premium for a group insurance policy based on loss or expense experience, or both, at the end of the first or any subsequent policy year, which may be made retroactive for such policy year.

(10) Notwithstanding any provision of any policy of insurance, certificate or service contract, whenever such insurance policy or certificate or service contract provides for reimbursement for any services which may be legally performed by any practitioner of the healing arts licensed to practice in this state, reimbursement under such insurance policy, certificate or service contract shall not be denied because of race, color or creed nor shall any insurer make or permit any unfair discrimination against particular individuals or persons so licensed.

(11) Favored agent or insurer: Coercion of debtors. (A) No person may (i) require, as a condition precedent to the lending of money or extension of credit, or any renewal

thereof, that the person to whom such money or credit is extended or whose obligation the creditor is to acquire or finance, negotiate any policy or contract of insurance through a particular insurer or group of insurers or producer or group of producers; (ii) unreasonably disapprove the insurance policy provided by a borrower for the protection of the property securing the credit or lien; (iii) require directly or indirectly that any borrower, mortgagor, purchaser, insurer or producer pay a separate charge, in connection with the handling of any insurance policy required as security for a loan on real estate or pay a separate charge to substitute the insurance policy of one insurer for that of another; or (iv) use or disclose information resulting from a requirement that a borrower, mortgagor or purchaser furnish insurance of any kind on real property being conveyed or used as collateral security to a loan, when such information is to the advantage of the mortgagee, vendor or lender, or is to the detriment of the borrower, mortgagor, purchaser, insurer or the producer complying with such a requirement.

(B) (i) Subparagraph (A)(iii) of this subdivision shall not include the interest which may be charged on premium loans or premium advancements in accordance with the security instrument. (ii) For purposes of subparagraph (A)(ii) of this subdivision, such disapproval shall be deemed unreasonable if it is not based solely on reasonable standards uniformly applied, relating to the extent of coverage required and the financial soundness and the services of an insurer. Such standards shall not discriminate against any particular type of insurer, nor shall such standards call for the disapproval of an insurance policy because such policy contains coverage in addition to that required. (iii) The commissioner may investigate the affairs of any person to whom this subdivision applies to determine whether such person has violated this subdivision. If a violation of this subdivision is found, the person in violation shall be subject to the same procedures and penalties as are applicable to other provisions of section 38a-815, subsections (b) and (e) of section 38a-817 and this section. (iv) For purposes of this section, "person" includes any individual, corporation, limited liability company, association, partnership or other legal entity.

(12) Refusing to insure, refusing to continue to insure or limiting the amount, extent or kind of coverage available to an individual or charging an individual a different rate for the same coverage because of physical disability, mental or nervous condition as set forth in section 38a-488a or intellectual disability, except where the refusal, limitation or rate differential is based on sound actuarial principles or is related to actual or reasonably anticipated experience.

(13) Refusing to insure, refusing to continue to insure or limiting the amount, extent or kind of coverage available to an individual or charging an individual a different rate for the same coverage solely because of blindness or partial blindness. For purposes of this subdivision, "refusal to insure" includes the denial by an insurer of disability insurance coverage on the grounds that the policy defines "disability" as being

presumed in the event that the insured is blind or partially blind, except that an insurer may exclude from coverage any disability, consisting solely of blindness or partial blindness, when such condition existed at the time the policy was issued. Any individual who is blind or partially blind shall be subject to the same standards of sound actuarial principles or actual or reasonably anticipated experience as are sighted persons with respect to all other conditions, including the underlying cause of the blindness or partial blindness.

(14) Refusing to insure, refusing to continue to insure or limiting the amount, extent or kind of coverage available to an individual or charging an individual a different rate for the same coverage because of exposure to diethylstilbestrol through the female parent.

(15) (A) Failure by an insurer, or any other entity responsible for providing payment to a health care provider pursuant to an insurance policy, to pay accident and health claims, including, but not limited to, claims for payment or reimbursement to health care providers, within the time periods set forth in subparagraph (B) of this subdivision, unless the Insurance Commissioner determines that a legitimate dispute exists as to coverage, liability or damages or that the claimant has fraudulently caused or contributed to the loss. Any insurer, or any other entity responsible for providing payment to a health care provider pursuant to an insurance policy, who fails to pay such a claim or request within the time periods set forth in subparagraph (B) of this subdivision shall pay the claimant or health care provider the amount of such claim plus interest at the rate of fifteen per cent per annum, in addition to any other penalties which may be imposed pursuant to sections 38a-11, 38a-25, 38a-41 to 38a-53, inclusive, 38a-57 to 38a-60, inclusive, 38a-62 to 38a-64, inclusive, 38a-76, 38a-83, 38a-84, 38a-117 to 38a-124, inclusive, 38a-129 to 38a-140, inclusive, 38a-146 to 38a-155, inclusive, 38a-283, 38a-288 to 38a-290, inclusive, 38a-319, 38a-320, 38a-459, 38a-464, 38a-815 to 38a-819, inclusive, 38a-824 to 38a-826, inclusive, and 38a-828 to 38a-830, inclusive. Whenever the interest due a claimant or health care provider pursuant to this section is less than one dollar, the insurer shall deposit such amount in a separate interest-bearing account in which all such amounts shall be deposited. At the end of each calendar year each such insurer shall donate such amount to The University of Connecticut Health Center.

(B) Each insurer or other entity responsible for providing payment to a health care provider pursuant to an insurance policy subject to this section, shall pay claims not later than:

(i) For claims filed in paper format, sixty days after receipt by the insurer of the claimant’s proof of loss form or the health care provider’s request for payment filed in accordance with the insurer’s practices or procedures, except that when there is a

deficiency in the information needed for processing a claim, as determined in accordance with section 38a-477, the insurer shall (I) send written notice to the claimant or health care provider, as the case may be, of all alleged deficiencies in information needed for processing a claim not later than thirty days after the insurer receives a claim for payment or reimbursement under the contract, and (II) pay claims for payment or reimbursement under the contract not later than thirty days after the insurer receives the information requested; and

(ii) For claims filed in electronic format, twenty days after receipt by the insurer of the claimant's proof of loss form or the health care provider's request for payment filed in accordance with the insurer's practices or procedures, except that when there is a deficiency in the information needed for processing a claim, as determined in accordance with section 38a-477, the insurer shall (I) notify the claimant or health care provider, as the case may be, of all alleged deficiencies in information needed for processing a claim not later than ten days after the insurer receives a claim for payment or reimbursement under the contract, and (II) pay claims for payment or reimbursement under the contract not later than ten days after the insurer receives the information requested.

(C) As used in this subdivision, "health care provider" means a person licensed to provide health care services under chapter 368d, chapter 368v, chapters 370 to 373, inclusive, 375 to 383c, inclusive, 384a to 384c, inclusive, or chapter 400j.

(16) Failure to pay, as part of any claim for a damaged motor vehicle under any automobile insurance policy where the vehicle has been declared to be a constructive total loss, an amount equal to the sum of (A) the settlement amount on such vehicle plus, whenever the insurer takes title to such vehicle, (B) an amount determined by multiplying such settlement amount by a percentage equivalent to the current sales tax rate established in section 12-408. For purposes of this subdivision, "constructive total loss" means the cost to repair or salvage damaged property, or the cost to both repair and salvage such property, equals or exceeds the total value of the property at the time of the loss.

(17) Any violation of section 42-260, by an extended warranty provider subject to the provisions of said section, including, but not limited to: (A) Failure to include all statements required in subsections (c) and (f) of section 42-260 in an issued extended warranty; (B) offering an extended warranty without being (i) insured under an adequate extended warranty reimbursement insurance policy or (ii) able to demonstrate that reserves for claims contained in the provider's financial statements are not in excess of one-half the provider's audited net worth; (C) failure to submit a copy of an issued extended warranty form or a copy of such provider's extended warranty reimbursement policy form to the Insurance Commissioner.

(18) With respect to an insurance company, hospital service corporation, health care center or fraternal benefit society providing individual or group health insurance coverage of the types specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469, refusing to insure, refusing to continue to insure or limiting the amount, extent or kind of coverage available to an individual or charging an individual a different rate for the same coverage because such individual has been a victim of family violence.

(19) With respect to an insurance company, hospital service corporation, health care center or fraternal benefit society providing individual or group health insurance coverage of the types specified in subdivisions (1), (2), (3), (4), (6), (9), (10), (11) and (12) of section 38a-469, refusing to insure, refusing to continue to insure or limiting the amount, extent or kind of coverage available to an individual or charging an individual a different rate for the same coverage because of genetic information. Genetic information indicating a predisposition to a disease or condition shall not be deemed a preexisting condition in the absence of a diagnosis of such disease or condition that is based on other medical information. An insurance company, hospital service corporation, health care center or fraternal benefit society providing individual health coverage of the types specified in subdivisions (1), (2), (3), (4), (6), (9), (10), (11) and (12) of section 38a-469, shall not be prohibited from refusing to insure or applying a preexisting condition limitation, to the extent permitted by law, to an individual who has been diagnosed with a disease or condition based on medical information other than genetic information and has exhibited symptoms of such disease or condition. For the purposes of this subsection, "genetic information" means the information about genes, gene products or inherited characteristics that may derive from an individual or family member.

(20) Any violation of sections 38a-465 to 38a-465q, inclusive.

(21) With respect to a managed care organization, as defined in section 38a-478, failing to establish a confidentiality procedure for medical record information, as required by section 38a-999.

(22) Any violation of sections 38a-591d to 38a-591f, inclusive.

(1955, S. 2817d; 1967, P.A. 852, S. 1; 1969, P.A. 651, S. 1; P.A. 73-73, S. 2; P.A. 79-310; 79-318, S. 1; P.A. 80-259, S. 1; P.A. 82-353, S. 17; P.A. 84-189; P.A. 86-70; 86-407; P.A. 87-16; P.A. 89-250; P.A. 90-121; P.A. 91-17; P.A. 94-86, S. 2; P.A. 95-79, S. 150, 189; 95-193, S. 3; P.A. 96-193, S. 19, 20, 36; P.A. 97-95; 97-126, S. 3; 97-202, S. 13, 18; P.A. 98-27, S. 10, 11; 98-163, S. 3, 4; 98-214, S. 30; P.A. 99-59, S. 2; 99-284, S. 30, 32, 60; P.A. 01-111; June Sp. Sess. P.A. 01-4, S. 43; P.A. 03-57, S. 1; P.A. 05-61, S. 2; 05-97, S. 2; 05-140, S. 1; P.A. 08-175, S. 21; 08-178, S. 50; P.A. 11-

58, S. 15, 85; 11-163, S. 1; P.A. 12-145, S. 36–39; P.A. 13-139, S. 35; P.A. 14-122, S. 172.)

History: 1967 act added Subdiv. (7); 1969 act substituted "practitioner of the healing arts licensed to practice in this state" for "person licensed under the provisions of chapter 372" in Subdiv. (7); P.A. 73-73 substituted "insurance policies" for "policy contracts" and restated provisions re misrepresentation of policy terms in Subdiv. (1), inserted new Subdivs. (6) to (8), renumbering former Subdivs. (6) and (7) accordingly, and added Subdiv. (11); P.A. 79-310 added Subdiv. (12); P.A. 79-318 added Subdiv. (6)(o); P.A. 80-259 included refusal to insure because of physical disability or mental retardation in Subdiv. (12); P.A. 82-353 provided that the declination, cancellation or nonrenewal of a private passenger nonfleet auto insurance policy for one or more of the reasons specified in Sec. 38-175w is an unfair insurance practice; P.A. 84-189 added Subdiv. (13), providing that the denial of insurance based on the individual's exposure to diethylstilbestrol is an unfair practice; P.A. 86-70 inserted as Subdiv. (13) prohibition against refusing to insure or otherwise discriminating against an individual due to his blindness or partial blindness, and renumbered the prior Subdiv. (13) concerning exposure to diethylstilbestrol as Subdiv. (14); P.A. 86-407 added new Subdiv. (15) defining as an unfair practice the failure of an insurer to pay accident and health claims within 45 days of receipt by the insurer of proof of loss, with certain exceptions; P.A. 87-16 added Subdiv. (16) defining as an unfair practice the failure to include in the settlement on a totalled motor vehicle an amount equal to what the sales tax would be on the settlement; P.A. 89-250 amended Subdiv. (15) to require that insurers report the percentage of health and accident insurance claims paid more than 45 days after receipt of proof of loss and the total amount of interest paid on such claims; P.A. 90-121 amended Subdiv. (15) to increase the interest rate from 12% to 15% for the failure of an insurer to pay accident and health claims within 45 days of receipt by the insurer of proof of loss and to provide that if interest due a claimant is $1 or less, the insurer shall deposit that amount in a separate interest-bearing account and at the end of each calendar year the funds shall be divided in half and donated to The University of Connecticut Health Center and Uncas-on-Thames Hospital; Sec. 38-61 transferred to Sec. 38a-816 in 1991; P.A. 91-17 amended Subdiv. (15) to delete the requirement that insurers report to the insurance commissioner the total amount of interest paid on health and accident claims paid more than 45 days after the receipt of proof of loss; in 1993 a reference to Sec. 38a-140 was inserted editorially in Subdiv. (15) to replace reference to Sec. 38a-141 which was repealed by P.A. 92-112; P.A. 94-86 added Subdiv. (17) re extended warranty providers. (Revisor's note: A reference in Subdiv. (15) to Sec. 38a-79 was deleted editorially by the Revisors, that section having been repealed by P.A. 94-39); P.A. 95-79 amended Subdiv. (11) to redefine "person" to include a limited liability company, effective May 31, 1995; P.A. 95-193 added Subdiv. (18) re prohibition against refusing to insure victim of family violence; P.A. 96-193 substituted

"producer" for "agent" and "broker" in Subdivs. (8) and (11), effective June 3, 1996 (Revisor's note: In 1997 in Subdiv. (8) the phrase "... benefit from any insurers ..." was changed editorially by the Revisors to " ... benefit from any insurer ..." for consistency, and in Subdiv. (11)(a)(iii) the word "or" was substituted for the comma before "producer" in the phrase "... borrower, mortgagor, purchaser, insurer, producer pay a separate ..."); P.A. 97-95 added Subdiv. (19) re use of genetic information for health insurance; P.A. 97-126 amended Subdiv. (18) by adding reference to Sec. 38a-469(10); P.A. 97-202 added new Subdiv. (20) re violations of viatical settlement provisions, effective January 1, 1998; P.A. 98-27 amended Subdivs. (8) and (11) to make technical changes; P.A. 98-163 amended Subdiv. (15) by adding failure to pay claims to health care providers and deleted one-half donation to the Uncas-on-Thames Hospital, effective January 1, 1999, and applicable to contracts entered into or renewed after that date; P.A. 98-214 amended Subdiv. (15) to delete reference to Sec. 38a-65; P.A. 99-59 amended Subdiv. (15) to substitute "38a-830" for "38a-831"; P.A. 99-284 amended Subdiv. (15) re accident and health claims to designate existing provisions as Subpara. (A) and to substitute "within the time periods set forth in subparagraph (B) of this subdivision" for "within forty-five days, or as otherwise stipulated by contract, of receipt by an insurer of the claimant's proof of loss ..." and "with the forty-five-day period" and to add new Subpara. (B) re time period for paying claims and extensions for alleged deficiencies in information needed for processing and, effective July 1, 2000, added new Subdiv. (21) re failure to establish a confidentiality procedure for medical record information; P.A. 01-111 added Subdiv. (15)(C) defining health care provider; June Sp. Sess. P.A. 01-4 amended Subdiv. (15) by adding provisions in Subparas. (A) and (B) re other entity responsible for providing payment to a health care provider pursuant to an insurance policy; P.A. 03-57 amended Subdiv. (15)(B) to add "as determined in accordance with section 38a-477"; P.A. 05-61 amended Subdiv. (1)(f) to include "an intentional misquote of a premium rate" and to reference purpose of inducing the "purchase" of any insurance policy; P.A. 05-97 added new Subdiv. (22) re violation of Sec. 38a-478m; P.A. 05-140 amended Subdiv. (20) to delete "subsection (a) of section 38a-11 and"; P.A. 08-175 amended Subdiv. (20) by substituting "38a-465q" for "38a-465m"; P.A. 08-178 added cite to Ch. 368d in Subdiv. (15)(C); P.A. 11-58 amended Subdiv. (22) to replace reference to Sec. 38a-478m with "sections 38a-591d to 38a-591f, inclusive", effective July 1, 2011, and amended Subdiv. (15)(B) by designating existing provision re payment schedule as clause (i) and amending same to change time period for payment to be provided to providers from 45 days to 60 days for claims filed in paper format and by adding clause (ii) re 20-day time period for payment of claims filed in electronic format, effective January 1, 2012; P.A. 11-163 amended Subdiv. (12) to add "mental or nervous condition as set forth in section 38a-488a"; P.A. 12-145 made technical changes in Subdivs. (1), (6), (9) and (11), effective June 15, 2012; P.A. 13-139 amended Subdiv. (12) by substituting "intellectual disability" for "mental retardation"; P.A. 14-122 made a technical change in Subdiv. (7).

Annotations to former section 38-61:

Cited. 186 C. 507; 192 C. 124. Legislative intent is to make insurance practices subject to both the Connecticut Unfair Insurance Practices Act and the Connecticut Unfair Trade Practices Act. 199 C. 651. Cited. 206 C. 668; 212 C. 652; 216 C. 830; 225 C. 566.

Cited. 13 CA 208; 23 CA 585.

Cited. 40 CS 299; Id., 336.

Annotations to present section:

Cited. 219 C. 644; 229 C. 842; 231 C. 756; 238 C. 216; 239 C. 658.

Cited. 28 CA 660; 45 CA 368.

Subdiv. (1):

Trial court properly determined that plaintiff failed to allege facts sufficient to state a cause of action under CUIPA, which prohibits, inter alia, misrepresentations in insurance policies; although plaintiff alleged in complaint that certificate of liability insurance concerning home improvement contractor's coverage under an insurance policy issued by defendant insurance liability carrier was deceptive insofar as it would lead a reasonable person to believe that the contractor had secured insurance coverage for a full year, such an allegation was in direct conflict with certificate language, which repeatedly distinguished between policy expiration and cancellation. 280 C. 619.

Subdiv. (6):

Right to assert a private cause of action for CUIPA violations through CUTPA does not extend to third parties absent subrogation or a judicial determination of insured's liability. 94 CA 41.

Subdiv. (10):

"Practitioner of the healing arts" is defined pursuant to Sec. 20-1 and includes podiatrists; insurer's practice of reimbursing podiatrists and medical doctors at different rates for same services does not constitute "unfair discrimination"; Subdiv. bars denial of reimbursement based on particular license held, but does not preclude setting different reimbursement rates based on particular license held. 302 C. 464.