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 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, lightening 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

Noncompliance with this regulation constitutes a violation of § 10-3-1104, C.R.S., and subjects the noncomplying entity to the sanctions specified in §10-3-1108, C.R.S., and all other sanctions and penalties allowed by law, including the imposition of fines and the suspension or revocation of insurance licenses.

Section 17 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 insurance licenses.

Section 18 Effective Date

This regulation is effective on July 15, 2011.

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.

Repealed and Repromulgated (In Full) Regulation 5-1-2 Application and Binder Forms

Section 1. Authority

This regulation is promulgated pursuant to § § 10-1-109 and 10-3-1110, C.R.S.

Section 2. Basis 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 and Scope

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.

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. Binder does not include conditional receipts by life insurance companies under which issuance 'of the policy or coverage under the policy is contingent upon the acceptability of the risk.

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. Enforcement

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

Section 7. Severability

If any provision of this regulation or the application thereof to any person or circumstances is for any reasons held to be invalid, the remainder of this regulation and the application of such provision shall not be affected in any way.

Section 8. Effective Date

This regulation is effective December 1, 2001.

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.

Repealed and Repromulgated Regulation 5-1-6 NATIONWIDE INLAND MARINE DEFINITION

Section 1. Authority

This amended regulation is promulgated under the authority of § 10-1-109, C.R.S.

Section 2. Basis and Purpose

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

Section 3. Applicability

Marine or transportation policies may cover under the following conditions:

A. Imports

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

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; or

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.

B. Exports

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.

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 ruling respecting domestic shipments shall apply. However, this provision shall not apply to long established methods of insuring certain commodities (e.g., cotton).

C. Domestic Shipments

1. 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 cover on premises owned, leased or operated by the consignor.

2. 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 assured or purchaser.

D. 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)

The foregoing includes:

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

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

3. 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;

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

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

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

E. Personal Property Floater Risk covering individuals and/or generally

1. Personal Effects Floater Policies;

2. The Personal Property Floater;

3. Government Service Floaters;

4. Personal Fur Floaters;

5. Personal Jewelry Floaters;

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

7. Silverware Floaters;

8. 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;

9. Stamp and Coin Floaters;

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

11. 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;

12. 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

13. Live Animal Floaters.

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

1. Radium Floaters;

2. Physician's and Surgeons' Instrument Floaters. The policies may include coverage of furniture, fixtures and tenant Assured'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;

3. Pattern and Die Floaters;

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

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

6. Salesmen's Samples Floaters;

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

8. Live Animal Floaters;

9. 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.

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

    If written for account of owner, the coverage shall cease upon completion and acceptance thereof; or if written for account of a seller or contractor the coverage shall terminate when the interest of the seller or contractor ceases.

10. 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.

11. 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.

12. 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.

13. Garment Contractors Floaters.

14. Furriers or Fur Storers Customers Policies (i.e., policies under which certificates or receipts are issued by furriers or fur storers) covering specified articles the property of customers.

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

16. 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:

    a. The merchandise is specifically identifiable as encumbered to the bank or lending institution;

    b. 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;

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

        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.

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

18. 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.

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

    a. 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.

    b. Camera Dealers Policies, covering property consisting principally of cameras and their accessories.

    c. Furriers Dealers Policies, covering property consisting principally of furs and fur garments.

    d. 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.

    e. Stamp and Coin Dealers covering property of philatelic and numismatic nature.

    f. Jewelers Block Policies.

    g. Fine Arts Dealers.

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

20. Wool Growers Floaters.

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

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

23. Electronic Data Processing policies.

Section 4. Exceptions

Unless otherwise permitted, nothing in the foregoing shall be construed to permit marine or transportation policies to cover:

A. Storage of assured's merchandise, except as hereinbefore provided.

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

C. Furniture and fixtures and improvements and betterments to buildings.

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

Section 5. 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 shall not be affected thereby.

Section 6. Enforcement

Non-compliance 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 7. Effective Date

This regulation will be effective January 1, 2006.

Section 8. History

New regulation 78-14, effective 1978.

Amended, effective July 1, 1993.

Amended, effective March 1, 1994.

Amended effective January 1, 2006.

Amended Regulation 5-1-8 Concerning Claims-Made Insurance Policies

Section 1 Authority

This regulation is promulgated under the authority of § 10-1-109, C.R.S.

Section 2 Basis 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. 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 3 Rules

A. Definitions

1. "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 mat date is not covered.

2. "Extended reporting period" means a period allowing for making claims after expiration of a

claims-made policy. This is also known as a “tail” .

3. “Occurrence coverage” means an insurance policy that provides liability coverage only for injury or damage mat 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.

4. “Retroactive date” means the date on a claims-made policy which denotes the commencement date of coverage under the policy.

B. 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 FORMCLAIMS-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 at injured parry 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 4 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 including the imposition of fines and/or suspension or revocation of a license.

Section 5 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 6 Effective Date

This regulation shall be effective September 1, 2003.

Section 7 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.

Regulation 5-1-9 Regulation to Require Reporting of Financial and Statistical Data by Property and Casualty Insurance Companies

I. Authority

This regulation is promulgated pursuant to Section 10-4-404(1) and 10-1-109, C.R.S., authorizing the Commissioner to adopt rules and regulations regarding the reporting of financial and statistical data required by any laws or parts of laws of this state.

II. Purpose

The purpose of this regulation is to set forth the manner of reporting and the kinds of data to be reported by insurers to the Commissioner. This data will allow the Commissioner to determine solvency, financial, rating, and/or marketing problem areas by lines, sublines, or classes of insurance.

The data provided by insurers under this regulation will assist the Commissioner in the talking of action to prevent problems in the insurance market, i.e., unavailability and/or the affordability of insurance products, and will provide a basis for determining if rate and/or market conduct examinations should be conducted.

This regulation shall not be interpreted to limit the powers granted the Commissioner by any laws or part of laws of this state.

III. Definitions

A. Accelerated Reports. Statistical information in a form specified by the NAIC Statistical Handbook that provides data on a quarterly basis for the purpose of identifying emerging trends in the commercial liability lines; of insurance.

B. Fast Track Reports. Information generated from the NAIC Fast Track Monitoring System that gives sampling of significant data for property and casualty insurance on a quarterly basis by insurers comprising a major segment of the market for the lines of insurance indicated.

C. NAIC Statistical Handbook. The publication of the National Association of Insurance Commissioners (NAIC), as; revised October, 1980, that explains insurance statistical data and detail report formats to be furnished by statistical agents.

D. Participating Insurers. An insurer licensed to transact the business of property and casualty insurance in this state and who writes at least $100,000 in Colorado annual premium for any of the lines and classes listed under the “Fast Track Reports” and “Accelerated Reports” described in subsections VI(B)(2) and (3) below. (Please note that all property and casualty insurers whether or not they meet the $100,000 threshold described above must meet the annual reporting requirements of subsection VI(B)(1) below.)

E. Statistical Agent. An organization authorized by the Commissioner to gather and compile insurance statistical experience.

F. Statistical Plan. A system for collecting and recording insurance information.

IV. Powers and Duties

The Commissioner may enter into an agreement with any qualified data collection service corporation, association or other entity to undertake the compilation and analysis: of data collected pursuant to this regulation. The agreement may provide for the corporation, association, or other entity to prepare and distribute or make available data to insurers, government and the general public.

V. Financial Reporting

As a condition of doing business in the state, each insurer licensed to transact the business of property and casualty insurance shall report to the Commissioner financial data for the preceding year ended December 31.

A. Annual Statement. An annual statement shall be filed with the Commissioner on or before March 1st of each year, or a later date if appropriate, that provides financial information for the previous calendar year. The annual statement shall conform to the format prescribed and modified by the National Association of Insurance Commissioners (NAIC) and shall contain exhibits and schedules that follow specifications developed by the NAIC, which may include:

1. A balance sheet;

2. A statement of income;

3. Expense exhibits;

4. Investment schedules;

5. A reinsurance schedule; and

6. A loss development schedule.

B. insurance Expense Exhibit: An insurance expense exhibit shall be filed with the Commissioner on or before April 1 each year, or a later date if appropriate, that provides countrywide information on insurer expenses for the previous calendar year. The information included in this exhibit should be in the form prescribed and modified by the NAIC and may include:

1. An allocation of expenses by category of expense.

2. An allocation of premiums, losses and expenses by lines of business.

C. Other Schedules and Supplements. In addition to the above, other NAIC schedules may be requested at the discretion of the Commissioner. These additional NAIC schedules shall follow the format and detail prescribed by the NAIC.

VI. Statistical Reporting

As a condition of doing business in this state, each insurer licensed to transact the business of property and casualty insurance shall report to the Commissioner at least annually in such form and detail as may be required by the NAIC Statistical Handbook.

A. Statistical Agents. All insurance companies licensed to transact the business of property and casualty insurance in this state shall report their insurance statistical experience to a statistical agent authorized by the Commissioner or, with the Commissioner's approval, directly to the Commissioner. Such information shall be submitted in the form and detail outlined in statistical plans filed with the Commissioner. Insurers shall inform the Commissioner of their choice of statistical agent: and of any changes in a statistical agent. Statistical agents shall notify the Commissioner of all changes in their statistical plans or in their reporting formats. Statistical agents shall submit with each filing a complete list of all insurers whose information is included in the filing.

B. Statistical Reports. Every statistical agents shall report its insurance data compilation to the Commissioner in the form and detail contained in the NAIC Statistical Handbook.

1. Annual Compilations. At least annually, and as specified in the NAIC Statistical Handbook, compilations shall be submitted for specific Lines of insurance by statistical agents and those Insurers reporting their statistical experience directly to the Commissioner.

    a. Lines of Insurance. The following lines of insurance shall be included in annual compilations to the Commissioner or such other lines as may be specified in the NAIC Statistical Handbook:

        1. Automobile-Commercial

        2. Automobile-Private Passenger;

        3. Boiler and Machinery;

        4. Burglary;

        5. Businessowners;

        6. Commercial Multiple Peril;

        7. Crop-Hail;

        8. Farmowners;

        9. Fidelity and Surety;

        10. Fire and Extended Coverage;

        11. General Liability;

        12. Glass;

        13. Homeowners;

        14. Inland Marine;

        15. Personal Property other than Homeowners.

    b. Data Elements. All data elements and display formats for the annual compilations shall be those specified in the NAIC Statistical Handbook, except that compilation reports for lines of insurance shall include the following data elements:

        1. premiums written;

        2. premiums earned;

        3. losses paid;

        4. loss adjustment expenses paid;

        5. losses outstanding;*

        6. loss adjustment expenses outstanding;*

        7. number of claims;

8. territories.

NOTE: To the extent any of the above elements include incurred but not reported losses (IBNR) or estimates of IBNR's, these should be separately delineated.

* If not maintained separately, the aggregate reserves for both loss and loss adjustment expenses are to be reported.

c. Compilation Basis. The compilation basis for each line of insurance in each annual report shall be specified for that report by the NAIC Statistical Handbook, and should be one of the following:

1. calendar year;

2. accident year;

3. policy year.

2. Fast Track Reports: Data necessary to produce Fast Track Reports shall be submitted by participating insurers to statistical agents, or directly to the Commissioner upon approval, within 45 days of the close of the calendar quarter. All data elements specified shall be set out on a Colorado-wide and countrywide basis.

a. Loss Ratio Data. Participating insurers shall submit quarterly premium and loss data for the following Fast Track Lines and Classes, and as otherwise specified in the NAIC Statistical Handbook:

1. Private Passenger Liability;

2. Private Passenger Physical Damage

3. Commercial Auto Liability;

4. Commercial Auto Physical Damage;

5. Homeowners;

6. Dwelling Fire;

7. Dwelling Allied Lines;

8. Commercial Fire;

9. Commercial Allied Lines;

10. Farm Business;

11. Commercial Multiple Peril;

12. Liability Other than Auto;

13. Medical Malpractice.

b. Claim Reports. Participating insurers shall submit quarterly claim cost and claim frequency data for the following Fast Track Lines and Classes, and as otherwise

specified in the NAIC Statistical Handbook:

1. Private Passenger Comprehensive;

2. Private Passenger Collision;

3. Private Passenger Bodily Injury Liability;

4. Private Passenger Property Damage Liability;

5. Private Passenger Personal Injury Protection.

c. Report Formats. Statistical agents shall provide Fast Track Reports in the format prescribed by the NAIC Statistical Handbook within 60 days of the close of the calendar quarter for the Private Passenger Automobile and Homeowners lines of" insurance. Fast Track Reports for other lines of business shall be provided within 75 days of the close of the calendar quarter.

3. Accelerated Reports: Data necessary to produce Accelerated Reports shall be submitted by participating insurers to statistical agents, or directly to the Commissioner upon approval, within 60 days of the close of the calendar quarter. All data elements specified shall be set out on a Colorado-wide and countrywide basis.

a. Loss Ratio Data. Participating insurers shall submit premium and loss data for the following lines and classes, and as otherwise specified in the NAIC Statistical Handbook:

1. Owners, Landlords and Tenants Liability;

2. Manufacturers and Contractors Liability;

3. Products Liability (countrywide only);

4. Premises/Operations Liability;

5. Liquor Law Liability;

6. Lawyers Professional Liability;

7. Municipal Liability;

8. Public School Liability;

9. Day Care Liability;

10. Recreational Liability;

11. Public Official Liability;

12. Directors and Officers Liability.

b. Data Elements. Participating insurers shall submit such premium, loss and expense data that is necessary to generate Accelerated Reports in the form required by the NAIC Statistical Handbook including:

1. Direct premiums written;

2. Direct premiums earned, and;

3. Incurred losses, developed as the sum of the following:

    a) the dollar amount of paid losses, plus;

    b) the dollar amount allocated for loss adjustment expenses, plus;

    c) reserves for reported claims at the end of the quarter, minus;

    d) reserves for reported claims at the beginning of the quarter.

c. Report Formats. Statistical agents shall provide Accelerated Reports to the Commissioner in the format and within timeframes prescribed by the NAIC Statistical Handbook.

4. Statistical Compilations Available Upon Request: Upon a request by the Commissioner of any special reports, as detailed in the NAIC Statistical Handbook, the reports shall be produced by statistical agents, or insurers with prior approval for direct submission of reports to the Commissioner. These reports shall be compiled and submitted within reasonable timeframes.

VII. Due Date and Exemption

A. Statistical reports shall be due within the timeframes specified in the NAIC Statistical Handbook.

B. Acting upon an application, which shall state the reasons and their justifications for an exemption to the required submission date, submitted by a statistical agent or an individual insurer the Commissioner may allow a later submission date of the statistical data or report if the submission date required by this Regulation would create a substantial hardship.

VIII. Enforcement

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of any of the sanctions made available to the Commissioner in the Colorado Insurance Code which includes, but is not limited to, fines, cease and desist orders, and suspension and/or revocation of a license or certificate of authority.

IX. Separability

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 shall not be affected thereby.

X. Effective Date

This Regulation will be effective May 1, 1988.

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, 10-4-404, and 10-4-404.5, 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 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 of Insurance 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 of Insurance 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 of Insurance. 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 of Insurance 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 on using 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 of Insurance 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 of Insurance. In the case of rates requiring prior approval, if a rate increase has been implemented without Division of Insurance 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 of Insurance 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 of Insurance. 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. Company Specific: A separate filing must be submitted for each company. A single filing which is made for more than one company or for a group of companies is not permitted.

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 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 of Insurance 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 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 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 of Insurance 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, 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, 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 business 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 business 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 of Insurance.

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 of Insurance, 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 of Insurance.

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.

C. Rule Filing General Requirements

1. Required Forms: A fully completed Filing Form A is required. Filing forms are available from the Division of Insurance 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 of Insurance 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

Noncompliance with this regulation constitutes a violation of § 10-3-1104, C.R.S., and subjects the noncomplying entity to the sanctions specified in § 10-3-1108, C.R.S., and all other sanctions and penalties allowed by law, including the imposition of fines and the suspension or revocation of insurance licenses.

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 insurance licenses.

Section 8 Effective date

This regulation is effective August 1, 2009.

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 5-1-11 Risk Modification Plans

Section 1 Authority

This regulation is promulgated under the authority of § § 10-1-109, 10-4-401, 10-4-403, 10-4-404, and 104-408, C.R.S.

Section 2 Basis 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. 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 3 Rules

A. Definitions

1. “Anniversary date” means the annual anniversary of the date of issue of a policy as shown in the policy declaration.

2. “Certified workers” compensation risk management program1' 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.

3. “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.

4. “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.

5. “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 me 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.

6. “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.

7. “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 me 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.

8. “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.

9. “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.

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

11. “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

12. “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.

13. “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.

14. “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.

15. “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.

B. 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.

C. 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.

D. 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.

E. 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 insure l 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 mat 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.

F. 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%.

G. 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 me 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 l, 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 me given policy period

H. 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.

I. 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.

J. 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 4 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 winch include the imposition of fines and/or suspension or revocation of license.

Section 5 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 shall not be affected thereby.

Section 6 Dissemination

Each insurer or rating/advisory organization is instructed to distribute a copy of this regulation to all personnel engaged in activities requiring knowledge of this regulation, and to instruct them as to its scope and operation.

Section 7 Effective Date

This regulation is effective May 1, 2003.

Section 8 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 5-1-12 Concerning Warranties and Service Contracts

Section 1. Authority

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

Section 2. Background 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(7), 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.

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

Section 3. Scope

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:

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

“Contract” means a written agreement for consideration.

“Indemnify” means to make compensation for damage, loss, or injury suffered.

“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.

“Supplier” means the manufacturer, wholesaler or retailer of a product or thing being sold and warranted

or guaranteed.

“Written warranty” means

(A) Any written affirmation of fact or written promise made in connection with a sale of real or personnel 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

(B) Any undertaking in writing in connection with the sale of real or personnel 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:

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

2. 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.

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

4. 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(7), 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.* Enforcement

Any contract which is considered to be a contract of insurance based upon this regulation shall be subject to the rules and regulations of the insurance code as contained in Title 10 of the Colorado Revised Statutes.

Noncompliance with this regulation may result in the imposition of sanctions authorized in Article 3 of Title 10, C.R.S.

Section 7. 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 this regulation shall not be affected thereby.

Section 8. Effective Date

This regulation shall be effective January 1, 2002.

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.

AMENDED 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 pursuant to § § 10-1-109 and 10-4-1402, C.R.S.

Section 2 Basis 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 and Scope

This regulation shall apply to all insurers authorized to issue Type II insurance (as defined below in Section 4, Rules, A. 7.) 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 through the use of a risk manager employed or retained by such person, and 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 that term is 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 that term is 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: (i) insurance classified as Type I insurance by § 10-4-401(3)(a), C.R.S.; and (ii) title insurance.

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, Rules, A. 3. 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 by Section 4, Rules, B. 1. and 2. above, and the original disclosures required by Section 4, Rules, B. 3. 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 4, Rules, C. 1. 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 Enforcement

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of any sanction(s) allowed by law, including, without limitation, any one or more of the following: civil penalties, fines, license suspension, or license revocation.

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 the regulation shall not be affected.

Section 8 Effective Date

This regulation shall become effective on August 1, 2006.

Section 9 History

New Regulation effective January 15, 2000.

Amended regulation effective August 1, 2006.

Amended Regulation 5-1-14 Penalties For Failure To Promptly Address Property And Casualty First Party Claims

Section 1 . Authority

This regulation is promulgated pursuant to § § 10-1-109 and 10-3-1110, C.R.S.

Section 2 . Background and Purpose

Section 10-3-1110(2), C.R.S., authorizes the Commissioner of Insurance to promulgate rules and regulations with respect to the payment of benefits under group and individual contracts of property or casualty coverage. 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 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. This regulation applies to all first party property or casualty claims, except as provided pursuant to the Colorado Auto Accident Reparations Act, Part 7 of Article 4 or Title 10, C.R.S.

Section 4 . Rules

A. Timely Decisions and Payment of Benefits Pursuant to § 10-3-1110(2), C.R.S.

1. Penalties

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.

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:

a. If the claim is $100 or less, the penalty shall not be more than $20.00;

b. If the claim is more than $100, the penalty shall be 8% 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.

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 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; or

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

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

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

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

(6) Litigation is commenced on the claim; or

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

An insurer shall not fail to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy in order to influence settlements under other portions of the insurance policy coverage, pursuant to § 10-3-1104(l)(h)(XIII), C.R.S.

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.

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.

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.

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

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.

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

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:

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

2. Scene investigations;

3. Photographs, videotaped evidence;

4. Surveillance information;

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

6. Repair estimates;

7. Reports from relevant experts;

8. Credit reports and financial information;

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

10. Other relevant information.

Documentation that a reasonable investigation has been conducted shall be maintained in the claim file. Such documentation may include:

1. Adjuster's log notes;

2. Copies of written communications;

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

4. Status reports;

5. Evidence of payments; or

6. Other relevant information.

Section 10-3-1104(1)(h)(III), C.R.S., requires insurers to adopt and implement reasonable standards for the prompt investigation of claims.

When an investigation is incomplete or is otherwise continued and the insurer has not paid the claim within the time required under section 3., A. above (sixty (60) days after receipt of a valid and complete claim), 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 3., A., 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.

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.

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(l)(h), C.R.S. and this regulation have been met.

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, the remainder of the regulation shall not be affected thereby.

Section 7 . Effective Date

This regulation is effective *February 1, 2004.*

Section 8 . History

New Regulation 5-1-14 effective *May 1, 2001.*

Amended Regulation effective December 1, 2001.

Amended Regulation effective February 1, 2004.

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

Section 1. Authority

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

Section 2. Basis 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. Rules

A. Definitions

As used in this rule:

1. A “general liability policy” shall mean any insurance policy that provides insurance against negligent acts or omissions related to any contractor or completed operations activity.

2. An “additional insured by endorsement” shall mean a person or entity that is named on an endorsement to the general liability policy.

3. A “reasonable period of time” shall mean 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.

B. Notice Requirements

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.

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.

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

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.

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

Section 4. Enforcement

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of any of the sanctions made available in § § 10-3-1108 and 10-3-1109 C.R.S. and any other sanctions available under Colorado law.

Section 5. Severability

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

Section 6. Effective Date

This regulation is effective January 1, 2007.

Section 7. History

New Regulation, effective May 1, 2001.

Amended Regulation, effective January 1, 2007.

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

Repealed *effective 02/01/2005*

New Regulation 5-1-17 Availability of Fire Insurance During Wildfires

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 Basis 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. The rule applies to all insurers licensed to conduct business in this state.

Section 3 Rule

A. Fire Insurance Policy

Insurers are prohibited from refusing to issue fire insurance policies for property located within a federally designated disaster area, so designated because of wildfires, based on such property's zip code, county location, or distance from any wildfire. For the purpose of this rule a fire insurance policy is a policy of insurance on real and personal property which includes a non-commercial dwelling fire, homeowners, tenant homeowners and mobile homeowners policy.

B. Immediately Threatened Area

Insurers shall not refuse to issue a non-commercial dwelling fire, homeowners, tenant homeowners or mobile homeowners policy on property located within a federally designated disaster area, so designated because of existing wildfire where such refusal is based on the property's zip code, county location, or distance from any wildfire unless the property is located within an immediately threatened area as designated by the appropriate state, local or federal official. 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 prepared to be evacuated. An evacuation order may, but need not, be identified on a government website.

C. Reasonable Actions to Reduce the Risk of Fire

Insurers shall not refuse to renew an existing non-commercial dwelling fire, homeowners, tenant homeowners or mobile homeowners policy within an area that has been declared a federally designated disaster area for any reason that is related to existing wildfires. However, insurers as a condition of such renewal may require a property owner to take reasonable actions to reduce the risk of fire to such property. Reasonable actions to reduce the risk of fire include but are not limited to requiring the property owner to provide a defensible space around the structure as defined by reasonable underwriting guidelines of the insurer which are applied consistently by the insurer.

Section 4 Enforcement

Noncompliance with this Regulation may result, after proper notice and hearing, in the imposition of any lawful sanctions including the imposition of fines and suspension or revocation of license.

Section 5 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 shall not be affected thereby.

Section 6 Effective Date

This Regulation will be effective March 2, 2003.

Section 7 History

Issued as new Regulation 5-1-17, effective March 2, 2003.

Amended Regulation 5-2-1 Relative Value Schedule For No-Fault

Section 1 Authority

This regulation is promulgated under the authority of § § 10-1-109 and 10-4-714(l)(e) (effective until July 1, 2003 except for claims incurred under policies lawfully in effect as described in this regulation), C.R.S.

Section 2 Backgrounds And Purpose

The purpose of this regulation is to establish a standard to determine the average costs of specific types of services described in § § 10-4-706(l)(b) and (c), (2)(a), or (3)(b), C.R.S. for use by insurers as a basis for determining tort thresholds as provided for under § 10-4-714(1)(e), C.R.S.

Section 3 Applicability and Scope

On July 1, 2003, the Colorado Auto Accident Reparations Act, also known as the motor vehicle no-fault insurance law (“no fault law”), was repealed pursuant to § 10-4-726, C.R.S. Therefore, this regulation applies only to claims incurred under automobile insurance policies lawfully in effect under the no fault law.

Section 4 Rule

For the purpose of determining tort thresholds under the Colorado Auto Accident Reparations Act, insurers may use any current, reliable, nationally recognized and generally published, relative value/fee schedule that provides for Colorado average costs of specific services described in § 10-4-706(l)(b) and (c), (2)(a), or (3)(b), C.R.S. This standard does not apply to payment of benefits under § 10-4-706(l)(b) and (c), (2)(a), or (3)(b), C.R.S.

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

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 Effective Date

This regulation is effective February 1, 2004.

Section 8 History

Issued as Regulation 74-19, effective April 1, 1974.

Repealed and Reenacted as Regulation 74-19, effective December 1, 1990.

Renumbered as Regulation 5-2-1, effective June 1, 1992.

Amended as Regulation 5-2-1, effective February 1, 1995.

Amended as Regulation 5-2-1, effective November 1, 1997.

Amended as Regulation 5-2-1, effective: October 1, 1999.

Amended as Regulation 5-2-1, effective November 1, 2000.

Amended as Regulation 5-2-1, effective December 1, 2001.

Amended as Regulation 5-2-1, effective September 1, 2002.

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

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

Section 8 History

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 Background 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 and Scope

This regulation applies to all complying policies of automobile insurance.

Section 4 Rule

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 coverages.

Section 5 Enforcement

Noncompliance with this regulation may result, after notice and hearing, in the imposition of any lawful sanction including the imposition of fines and suspension or revocation of the certificate of authority.

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 shall not be affected.

Section 7 Effective Date

This regulation is effective February 1, 2006.

Section 8 History

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

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

3. Regulation Amended, effective May 1, 2003.

4. Regulation Amended, effective February 4, 2004.

5. Regulation Amended effective February 1, 2006

Amended Regulation 5-2-3 CONCERNING AUTOMOBILE INSURANCE POLICIES ISSUED OR RENEWED PRIOR TO JULY 1, 2003

Section 1 Authority

Section 1 Authority

This Regulation was originally promulgated by the Commissioner of Insurance and the Executive Director of the Department of Revenue under the authority of § 42-1-204, 10-1-109, 10-4-704, 10-4-718, 10-4-719.7(3), C.R.S as they existed on June 30, 2003. This Regulation is being amended under the authority of § §10-1-109 and 10-4-628(4), C.R.S. (2007).

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 C.R.S.10-4-706 et sq. as in effect on June 30, 2003. Sections duplicated in Regulation 5-2-12 have been deleted from this Regulation.

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.

The Division bases its interpretation of various statutory changes effected by the repeal of the no-fault law and the enactment of HB 03-1188 and SB 03-239 upon the constitutional prohibition against impairment of existing contracts and retrospective application of laws. These prohibitions are set forth in Article II, Section 11 of the Colorado Constitution and are elaborated upon in case law.

Section 3 Applicability

This regulation shall apply to all licensed insurers or producers in Colorado issuing private passenger automobile policies pursuant to Part 7 of Article 4 of Title 10 of the Colorado Revised Statutes.

Section 4 Rules

All statutory cites contained in this section that reflect Sections § 10-4-701 to 10-4-725, C.R.S, shall refer to the statutes in effect June 30, 2003, contained in the 2002 version of the Colorado Revised Statutes.

A. Definitions

1. “Complying policy” means a policy as defined in § 10-4-703(2), C.R.S. It also includes a policy subject to § 10-4-706(1)(a), C.R.S., issued for motorcycles and motor scooters.

2. “Private passenger motor vehicle” means any vehicle as defined in § 10-4-60l(2)(a) and (b), C.R.S.

3. “Week” means any seven (7) consecutive days.

B. Wage Loss Benefits

1. For personal injury protection (PIP) coverage pursuant to § 10-4-706(l)(d)(I), C.R.S., each insurer is obligated to pay the maximum $400 per week wage benefit, when the loss of gross income per week of an eligible injured person is $562.50 or more.

2. When the loss of gross income is less than $562.50 per week, wage benefit shall be computed by applying the formula as used in the following example:

Example:

Loss of Gross Income per Week	.	Wage Benefit Payable
$500	100% of the first $125	$ 125.00
.	70% of the next $125	+ 87.50
.	60% of the next $250	+ 150.00
.	.	Total $ 362.50

3. An eligible injured person shall be entitled to basic PIP wage loss benefits up to the $400 per week limit even though the loss is incurred in less than a full week.

C. Coordination Of Benefits

Except as provided in § 10-4-707(5), C.R.S., regarding workers' compensation, benefits payable under the Colorado Accident Reparations Act are “primary” . Some providers, to avoid duplication of benefits available through other insurance or contract rights, are required to coordinate their benefits as specified in § 10-4-709, C.R.S. Coordination of benefits shall not apply when personal injury benefits are not provided under a policy of automobile insurance.

Section 5 Enforcement

Noncompliance with this regulation may result, after notice and hearing, in the imposition of any lawful sanction including the imposition of fines and suspension or revocation of license.

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 shall not be affected thereby.

Section 7 Effective Date

Amended Regulation effective August 1, 2007.

Section 8 History

Originally issued as Regulation 74-20, effective July 1, 1974.

Repealed and replaced by Regulation 86-1, effective March 3, 1986.

Re-codified as Regulation 5-2-3, effective June 1, 1992.

Amended, effective date February 1, 1998.

Amended, effective December 1, 2000.

Amended, effective May 1, 2001.

Sections 1, 2, 3 (C) 2, 6 and 7 amended, effective February 1, 2004.

Amended, effective January 1, 2007.

Amended, effective August 1, 2007.

Amended Regulation 5-2-5 Fees For Arbitrators

Section 1 Authority

This regulation is promulgated under the authority of § § 10-1-109, and 10-4-708(1.8) (effective until July 1, 2003 except for claims incurred under policies lawfully in effect as described in this regulation), C.R.S.

Section 2 Background And Purpose

The purpose of this regulation is to adopt annual rules establishing fee guidelines for payment of arbitrators.

Section 3 Applicability and Scope

On July 1, 2003, the Colorado Auto Accident Reparations Act, also known as the motor vehicle no-fault insurance law (“no fault law”), was repealed pursuant to § 10-4-726, C.R.S. Therefore, this regulation applies only to claims incurred under automobile insurance policies lawfully in effect under the no fault law.

Section 4 Rule

Each arbitrator serving in Personal Injury Protection Dispute Arbitration matters shall be entitled to compensation in the following minimum amounts:

$150 for a case which is resolved without an arbitration hearing;

$300 for a case in which there was an arbitration hearing which was completed in two hearing days or less;

$500 for a case in which there was an arbitration hearing which was completed in more than two hearing days.

Responsibility for payment of arbitrator's fees shall be as set forth in Division of Insurance Regulation 5-2-7.

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

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 of such provision shall not be affected thereby.

Section 7 Effective Date

This regulation is effective February 1, 2004.

Section 8 History

Issued as Regulation 89-5, effective November 1, 1989.

Renumbered as Regulation 5-2-5, effective June 1, 1992.

Amended as Regulation 5-2-5, effective December 1, 1993.

Amended as Regulation 5-2-5, effective September 1, 1995.

Amended as Regulation 5-2-5, effective November 1, 1997.

Amended as Regulation 5-2-5, effective October 1, 1999.

Amended as Regulation 5-2-5, effective November 1, 2001.

Amended as Regulation 5-2-5, effective September 1, 2002.

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

Amended Regulation 5-2-6 AUTOMOBILE NO-FAULT COST CONTAINMENT OPTIONS

Section 7. History

Section 1. Authority

This regulation is promulgated under the authority of § § 10-1-109, 10-3-1110 and 10-4-706(2)(g), (effective until July 1, 2003) C.R.S.

Section 2. Background and Purpose

The purpose of this regulation is to provide rules for the proper implementation of automobile no-fault cost containment options and disclosure requirements for such cost containment options by automobile insurers licensed to conduct business in this state. On July 1, 2003, the Colorado Auto Accident Reparations Act, also known as the motor vehicle no-fault insurance law ("no fault law"), was repealed pursuant to § 10-4-726, C.R.S. Therefore, this regulation applies only to automobile insurance policies lawfully in effect under the no-fault law.

Section 3. Rules

All statutory cites contained in this section that reflect § § 10-4-701 to 725, C.R.S., shall refer to the statutes in effect June 30, 2003.

A. Definitions

1. "Coinsurance" means that the insured and the insurer will share all losses covered by the policy or a section of the policy in a proportion agreed upon in advance.

2. "Cost containment option" means the managed care arrangements through HMO's and PPO's, deductibles and/or coinsurance under medical and rehabilitation personal injury protection benefits,offered by the insurer or mandated to be offered by insurers and accepted by the insured on a voluntary basis.

3. "Deductible" means the portion or amount of an insured loss to be borne by the insured before he/she is entitled to recovery from the insurer.

4. "Health Maintenance Organization" (HMO) means the same as in § 10-16-102(23), C.R.S.

5. "Managed care arrangement" means an agreement offered by an insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services through the covered person's use of health care providers managed by, owned by, under contract with, or employed by the insurer because the insurer creates incentives, including financial incentives, for the covered person's use of those providers. A managed care arrangement includes, but is not limited to, and HMO or PPO arrangement.

6. "Preferred Provider Organization" or "PPO" means a network of hospital and/or healthcare providers that makes a contract with an insurer to provide comprehensive health care services at discounted fees for covered individuals who select the insurer's cost containment program. Insureds agreeing to use the preferred providers pay a discounted or lower premium.

B. Cost Containment Benefits

As of July 1, 2003, the Colorado Auto Accident Reparations Act was repealed. This section only applies to claims occurring under no fault automobile insurance policies issued prior to the repeal of the No-Fault Act.

1. The cost containment options apply only to the named insured, resident spouse, resident relative, and any person operating the described motor vehicle with the permission of the named insured or resident spouse, except that any policy of such permissive operator shall be primary. The cost containment options do not apply to non-resident relatives of the named insured, passengers injured in or pedestrians injured by the described motor vehicle.

2. If a managed care arrangement through an HMO or PPO is selected, the insurer must provide or make available for inspection, a listing of the participating providers within the HMO or PPO network. Furthermore, the insurer must explain to the insured the benefits, penalties and procedures that apply when the insured is receiving care outside the HMO or PPO network as a result of an automobile accident.

3. Managed care arrangement options through an HMO or PPO selected by the insured, must provide for medically reasonable and necessary care needed as a result of an automobile accident. Pursuant to § 10-4-708.6(3), C.R.S., any treatment or procedure recommended by a member of a managed care provider network shall be approved or denied within 20 business days after receipt of all information deemed necessary by the managed care organization to approve or deny the requested treatment or procedure. Information deemed necessary shall not be more than what is required in Colorado Insurance Regulation 5-2-8. The regulation shall not be deemed to change the time for payment of benefits as set forth in § 10-4-708, C.R.S. Treatment of injured parties should not be delayed by a managed care organization. Review for determining the reasonableness and necessity of medical treatment requested on behalf of an injured party should be conducted within the time guidelines of the national accrediting institutions for managed care organizations. Payment of claims should be based on the reasonableness and necessity of medical treatment and not on whether or not the treatment was pre-authorized.

4. If expenses are incurred outside the HMO or PPO network because the network does not have services available in the area where the insured resides or where the injury occurred, insurers are required to provide basic or reduced personal injury protection benefits whichever coverage is provided pursuant to § 10-4-706, C.R.S.

5. If the injured party elects to utilize a non-network provider when the HMO or PPO has services available in an area where the insured resides or where the injury occurred, payment of expenses incurred by the insured may be subject to a penalty. Insurers applying a penalty must actuarially justify the penalty.

6. Under any cost containment option, insurers cannot apply a deductible or coinsurance requirements in the following circumstances:

    a. To expenses incurred within the first twenty-four hours in which emergency treatment is rendered after an automobile accident; or

    b. Until the injured party's emergency medical condition has stabilized, whichever is longer, a. or b. of this subsection 6.; or

    c. Until the injured party has been transferred to a managed care provider if the cost containment option selected provides managed care through an HMO or PPO.

7. The injured party is deemed stable and qualified for transfer to a managed care provider when the injured party's condition has improved sufficiently so that transporting the injured party to the managed care provider would not endanger the life or limb of the injured party. The decision for transfer to a managed care provider shall be a joint decision by the

attending physician and the HMO or PPO network physician.

Section 4. Enforcement

Noncompliance with this regulation constitutes an unfair method of compliance or deceptive act or practice and may result, after proper notice of hearing, in the imposition of any lawful sanctions including the imposition of fines and suspension or revocation of license.

Section 5. 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 shall not be affected thereby.

Section 6. Effective Date

This regulation will be effective January 1, 2005.

Section 7. History

Originally issued as Regulation 91-11, effective November 1, 1991.

Re-codified as Regulation 5-2-6, effective June 1, 1992.

Regulation amended, effective January 1, 1999.

Regulation amended, effective December 1, 2000.

Regulation amended, effective July 1, 2002.

Emergency Regulation 02-E-6, effective July 1, 2002.

Temporary Regulation 02-E-6, effective October 1, 2002.

Amended Regulation 5- 2-6, effective January 1, 2003.

Sections 2, 3, 6 and 7 amended effective February 1, 2004.

Regulation amended, effective January 1, 2005.

Amended Regulation 5-2-7 Concerning Voluntary Arbitration for Personal Injury Protection Disputes

Section 8 History

Section 1 Authority

This regulation is promulgated under the authority of § § 10-1-109 and 10-4-708(1.9) (effective until July 1, 2003 except for claims incurred under policies lawfully in effect as described in this regulation), C.R.S.

Section 2 . Background and Purpose

The purpose of this regulation is to establish and implement rules applicable to disputes concerning denial or delay of Personal Injury Protection ("PIP") benefits and to set forth rules for selection of arbitrators when the parties have agreed to arbitrate under § 10-4-708 (1.5), C.R.S.

Section 3 Applicability and Scope

On July 1, 2003, the Colorado Auto Accident Reparations Act, also known as the motor vehicle no-fault insurance law ("no fault law"), was repealed pursuant to § 10-4-726, C.R.S. Therefore, this regulation applies only to claims incurred under automobile insurance policies lawfully in effect under the no fault law.

Section 4 Rules

A. COMMENCEMENT OF THE ARBITRATION PROCEEDING

1. If a dispute arises about personal injury protection benefits, the insured or the injured party entitled to such benefits and the insurer may agree to resolve the dispute through binding arbitration. In the absence of another agreement by the parties about applicable arbitration procedures, such arbitration shall be conducted pursuant to these rules.

2. Once the parties have voluntarily agreed to arbitrate under these rules, the agreement shall be memorialized in a document called "Agreement to Arbitrate" (Form 1).

3. Within ten days after the Agreement to Arbitrate is signed, the party claiming benefits shall serve on the opposing party an "Arbitration Claim" (Form 2). The Arbitration Claim shall conform substantially to Form 2.

4. The Arbitration Claim shall contain a short and plain statement of the claim alleging that the claimant is entitled to relief and specifying the amounts claimed.

5. Jurisdiction shall attach from the date of service of the Arbitration Claim.

B. SERVICE.

1. Service of the Arbitration Claim shall be accomplished by delivery of it with the recipient signing a delivery receipt, or by mailing the Arbitration Claim by certified mail, return receipt requested, to the particular claims person involved with the claim. Service shall be deemed complete on the date set forth in the signed delivery or certified mail receipt.

2. Except for the initial Arbitration Claim, service of other documents and papers may be made by regular mail or by personal delivery. Whenever a party is represented by an attorney, the service shall be made on the attorney. A Certificate of Mailing indicating the date of mailing shall be prepared for each document served by mail.

3. The provisions of Rule 6 of the Colorado Rules of Civil Procedure (C.R.C.P.), shall be used in computing time under this Regulation.

C. SELECTION OF ARBITRATORS

1. Within ten days after service of the Arbitration Claim as specified in section B. of these rules, and subject to C. 2., each party, or if there are more than two parties, each side, shall forthwith designate a competent and impartial arbitrator. The two arbitrators shall select a third arbitrator. If the two arbitrators are unable to agree on the third arbitrator, any party may request that the Commissioner appoint the third arbitrator in the manner specified in Subsection 3. of this section, The arbitrators shall agree on a chairperson from among themselves.

2. The parties may agree to arbitration before a single arbitrator. If the parties are unable to agree on the person to serve as the single arbitrator, any party may request that the Commissioner appoint the arbitrator in the manner specified in Subsection 3. of this section.

3. In the absence of agreement by the arbitrators or the parties, the arbitrator or arbitrators shall be appointed by the Commissioner. No person may be appointed by the Commissioner unless that person has filed with the Commissioner a consent to act as arbitrator.

4. A competent arbitrator is a person who meets the requirements of 13-71-109, C.R.S., to serve as a juror, except that the person need not reside in the county where the case is pending. A qualified arbitrator is a person who meets the competency requirements of these rules and has filed with the Commissioner a consent to serve as an arbitrator. To be an arbitrator, a person must be willing to sign an oath or affirmation under penalty of perjury that he or she meets the requirements of 13-71-109, C.R.S., will be completely impartial and will fairly and justly determine the issues in the case. An arbitrator need not be an attorney.

5. Promptly after an arbitrator is selected, he or she shall sign, file with the Commissioner and mail to each party the affirmation/oath set forth in Form 3.

6. Objection to an arbitrator is waived unless made in writing within 15 business days after notice of selection of the arbitrator has been given to the party making the objection.

7. In the case of a vacancy on the panel of arbitrators, the parties may agree to the matter being heard by the remaining arbitrators, or the vacancy shall be filled in a manner consistent with these rules.

D. ARBITRATORS TO BE PROVIDED WITH COPIES OF PLEADINGS AND DOCUMENTS

After the selection of arbitrators has been completed and their identities are known, each party shall promptly provide the arbitrators with a complete copy of the Arbitration Claim. On a timely basis, each party also shall provide the arbitrators with a copy of their Disclosure Statement, any supplement of their Disclosure Statement, the Request for Hearing, any motions and any other document, other than evidentiary documents, needed by the arbitrators for proper resolution of the case. The claimant shall provide his or her Notice to Insurer of Amount Claimed to the other party and the arbitrators within the time required in section H. 1. of these rules.

E. SETTING THE HEARING DATE

Unless the parties agree otherwise, the arbitration hearing shall be held within sixty days after the date of the Certificate of Mailing of the Request for Hearing to the other party or parties (Form 4). The arbitration hearing and any continuance of it shall be at a time and place set by the arbitrator(s) with the mutual consent of the parties. If the parties cannot agree, the arbitrator(s) shall set the time and place of the hearing on the basis of the least expense to the parties and then-witnesses.

F. ARBITRATOR'S OATH

A Request for Hearing shall not be served until the arbitrators have been selected and each arbitrator has served his or her signed Affirmation Oath Form as specified in section C. 5 of these rules.

G. DISCLOSURE

1. Unless extended by the Arbitrators, no later than thirty days after service of the Arbitration Claim, each party shall serve on all other parties a full and complete “Disclosure Statement” . A copy of the Disclosure Statement shall be provided to the arbitrators. The Disclosure Statement shall be prepared in conformance with the requirements of Rule 11, C.R.C.P., shall state the name of the party or parties on whose behalf it is presented and shall set forth in order the information with the designated captions as follows:

    a. Statement of Claim: A concise, plain and brief statement of all claims or defenses asserted by that party and identification by any party of all claims or defenses which, under the requirements of Rule 11, C.R.C.P., are or should be eliminated.

    b. Non-Expert Witnesses: Whether or not the party making the disclosure intends to call as a non-expert witness a particular person at the arbitration hearing, each party shall provide the names, addresses and telephone numbers of all persons known to have personal knowledge of relevant facts, together with the substance of their knowledge. If a privilege is claimed, the other party(s) shall be notified in writing of the nature of the privilege. Each party also shall identify those witnesses the party intends to call to testify. Each party shall set forth the names of witnesses whose testimony will be submitted at the hearing by deposition.

    c. Expert Witnesses: Each party shall set forth the name, address and a brief summary of the qualifications of any expert the party intends to call at the arbitration hearing, together with a statement as to each such expert which sets forth the substance of the opinions to which the expert is expected to testify. If the identity of a party's expert(s) is not known, the party shall disclose the anticipated area of expertise and provide a statement of probable subject matter.

    d. Affidavits: Each party shall set forth the name, address and telephone number of each person whose affidavit is to be submitted at the hearing, together with a summary of the anticipated contents of that affidavit. A copy of the affidavit to be presented to the arbitrators must be provided to all other parties no later than the date permitted for supplementing the Disclosure Statement. Any other party may subpoena the affiant to the arbitration hearing for cross-examination.

    e. Exhibits: Whether or not the party making disclosure will rely on a particular document or thing as an exhibit at the arbitration hearing, each party shall provide a listing of all relevant documents and things followed by production or availability for inspection and copying of each such document or thing for which privilege is not claimed. If a privilege is claimed, the other party(s) shall be notified in writing of the nature of the privilege. Each party also shall identify those exhibits the party intends to introduce as evidence.

    f. Non-Listed Exhibits and Witnesses: In the sole discretion of the arbitrators, a witness or exhibit not listed as required by these rules may not be used as evidence at the hearing.

    g. Damages: Each party shall set forth a detailed itemization of all damages, including, but not limited to, benefits claimed, interest, expenses, costs and reasonable

attorneys fees, together with a description of the precise method used for calculating the damages claimed.

h. Stipulations: Each party shall provide a listing of any stipulations or agreed facts and a listing of any stipulations offered or requested for the arbitration hearing.

2. A party may supplement a Disclosure Statement no later than twenty days prior to the arbitration hearing as follows:

a. The matters in G. 1 if not known at the time of the filing of the Disclosure Statement. The supplementation shall state as to why any additional witness or exhibit could not have been disclosed earlier.

b. Expert witnesses not known at the time of the filing of the Disclosure Statement, if the expert was identified in the Disclosure Statement by area of expertise and a statement of the probable subject matter of the expert's testimony and/or any opposing or rebuttal expert responding to an opposing party's designation. In addition to identifying the expert as required by section G. 1. c., the supplementation shall set forth a statement of the opinions of such additional expert and statement about why such additional expert could not have been disclosed earlier. No later than seven business days after receipt of an opposing party's supplemental designation of an expert under section G. 1. c., an opposing party may designate an opposing or rebuttal expert to challenge an expert opinion first learned of in the opposing party's supplementation. A statement of such opposing or rebuttal expert's opinions shall be served with the designation. In the discretion of the arbitrators, an expert not listed as required by these rules may not testify at the hearing.

3. A party may supplement stipulations under section G. 1. h. at any time.

4. Except for the information to be submitted by the claimant in the Notice to Insurer of Amount Claimed, the information provided in a party s Disclosure Statement, as supplemented, shall be binding on that party unless the interests of justice require otherwise. Except as set forth in section G. 2. b. above, no subsequent endorsement (listing) shall be permitted later than twenty days before the date set for the arbitration hearing. Authenticity and admissibility of exhibits shall be deemed admitted unless objected to in writing at least ten days before the arbitration hearing. Any objection shall be provided to the arbitrators and served on all other parties.

5. Compliance with this disclosure rule is mandatory.

H. NOTICE TO INSURER OF AMOUNT CLAIMED

1. No later than twenty days prior to the commencement of the arbitration hearing, the party claiming the benefits shall serve on all parties a separate document captioned “Notice to Insurer of Amount Claimed” , which shall set forth the amount claimed and in controversy. Such Notice shall include no more than those amounts the insured claims were denied or not timely paid by the insurer and the amount, if any, claimed for reasonable attorney's fees (Form 5).

2. The Notice to Insurer of Amount Claimed must be served on all parties no later than twenty days prior to the commencement of the arbitration hearing by personal delivery or by mail. If mailed, the Notice to Insurer of Amount Claimed must be received by the opposing party no later than twenty days prior to the hearing. A copy of the Notice to Insurer of Amount Claimed shall be provided to the arbitrators prior to the hearing.

3. If such Notice to Insurer of Amount Claimed is not timely served, there shall be no award of attorneys' fees to the person claiming benefits, unless the arbitrators determine that the failure was the result of “excusable neglect” , in which case the arbitration hearing shall be continued to a date at least twenty days after the notice was filed.

I. DISCOVERY

1. Discovery under these rules shall be limited to the following:

   a. A party may take one discovery deposition of each opposing party and one deposition of each expert. The number of depositions taken for perpetuation of testimony for use at the arbitration hearing is not limited. Except that matters concerning such discovery shall be decided by the arbitrators, the manner and proceeding by way of deposition and the use of depositions shall otherwise be governed by Rules 26, 28, 29, 30, 32, 45, and 121, C.R.C.P.

   b. A party may serve one set of written interrogatories upon each opposing party. Except that responses to such interrogatories shall be due within fifteen days after service and that matters concerning such discovery shall be decided by the arbitrators, the scope and manner of proceeding by way of interrogatories and the use of interrogatories shall be governed by Rules 26 and 33, C.R.C.P. The number of interrogatories to any one party shall not exceed fifteen, each of which shall consist of only a single question.

   c. When there is in controversy the mental or physical condition (including the blood group) of a party or of a person in the custody or under the legal control of a party, an adverse party may obtain a mental, physical, vocational and/or rehabilitation examination of that party or person upon reasonable written notice to such party or person. Otherwise, with the exception that matters concerning such discovery shall be decided by the arbitrators instead of the court, the provisions of Rule 35, C.R.C.P., shall apply to such examinations.

   d. A party may serve one request for production of documents upon each opposing party. Inspection and copying of documents or tangible things and entry, inspection or testing of land or property shall be accomplished pursuant to Rule 34, C.R.C.P., with the exception that responses to such requests for production shall be within fifteen days after service and that matters concerning such discovery shall be decided by the arbitrators.

   e. Every party is under a continuing duty to timely supplement or amend responses pursuant to Rule 26(e), C.R.C.P.

2. All discovery under these rules shall be fully completed no later than fifteen days before the date set for the arbitration hearing.

J. PRE-HEARING MOTIONS

1. Any motion made prior to the time the arbitrators are selected shall be determined by the Commissioner, unless the Commissioner determines that such a motion should be heard after the arbitrators are selected. Any motion concerning selection and qualification of the arbitrators shall be heard and determined by the Commissioner in accordance with Rule 121, Section 1-15, C.R.C.P.

2. Every other pre-arbitration hearing motion shall be decided by the arbitrators. The manner of hearing, form and content of the motion shall be at the discretion of the arbitrators.

K. SUBPOENAS

The arbitrators may issue or cause to be issued subpoenas authorized by Rule 45, C.R.C.P. Upon application by a party or the arbitrators to the district court in the county in which the arbitration is pending, a subpoena issued pursuant to these rules shall be enforceable in the manner provided by law for enforcement of subpoenas in civil actions. Fees for attendance as a witness shall be the same as for witnesses in the district court.

L. THE HEARING-POWERS OF THE ARBITRATORS

1. Procedure at hearings shall be informal, and strict rules of evidence shall not be applicable except as necessitated in the opinion of the arbitrators by the requirements of justice. Any arbitrator may administer oaths to witnesses and interpreters.

2. A party shall be entitled to attend hearings, personally or with counsel, and participate in the proceedings. Participation may include the filing of briefs and affidavits. Upon agreement of all parties, the proceedings may be confidential and closed to the public.

3. If without reasonable cause a party who has been duly notified of the hearing fails to prosecute or defend at the arbitration hearing, the arbitrators may proceed with the hearing and decide the case on the evidence that is presented.

4. No record of the proceedings is required. After the award has been filed, all evidence, documents and exhibits shall be returned to the party or witness who provided them.

M. THE AWARD

A majority decision of the arbitrators on any claim shall constitute a valid award. The arbitrators shall file their award with the Commissioner within ten days after the hearing and mail or deliver a copy to each party or each party's attorney.

N. CONTENTS OF THE AWARD

The award shall set forth:

1. The recommended heading (See Forms 6A and 6B);

2. The dates of the Arbitration Claim and effective service of the Notice to Insurer of Amount Claimed;

3. The title of the document shall be “Arbitration Award” ;

4. The full case name;

5. The identities of the parties who were present at the hearing either in person or by counsel and a finding that any non-appearing party was duly notified of the hearing;

6. That the arbitrators have found in favor of the particular party by name and party designation and against a particular party by name and party designation;

7. If required by statute, the arbitrators' special findings, if any;

8. The amount of PIP benefits awarded, if any;

9. The amount of interest on the PIP benefits awarded accruing to the date of the award, as

provided under § 10-4-708(1.8), as well as an additional statement that such interest shall continue to accumulate until the award is paid;

10. The amount of arbitrators' fees and costs to be paid, and a designation of what portion of such amount is to be paid by one or both parties pursuant to § 10-4-708 (1.6), C.R.S.;

11. The amount of reasonable attorney's fees awarded pursuant to § 10-4-708 (1.7)(c)(I), (II), (III)or(IV),C.R.S., if any;

12. The amount of treble damages awarded for willful and wanton conduct of the insurer, if any, under § 10-4-708 (1.8), C.R.S.

13. A signature line for each arbitrator; and

14. The date of the award, which will be the date the last arbitrator signs the award.

O. COMPENSATION OF ARBITRATORS

Compensation of arbitrators and all other fees and expenses of the arbitration, not including reasonable attorneys' fees, shall be paid by the parties pursuant to a decision of the arbitrators under § 10-4-708 (1.6), C.R.S. Such arbitrators' fees and expenses maybe allocated among the parties as the arbitrators deem just.

P. ATTORNEYS' FEES:

1. In determining the amount of attorneys' fees, if any, to be awarded to the insured, the arbitrators shall consider the following:

    a. The award of attorneys' fees to the insured shall be in direct proportion to the degree by which the insured was successful in the arbitration proceeding. The determination of the degree of the insured's success shall be based upon a comparison of the amount of PIP benefits claimed as set forth in the Notice to Insurer of Amount Claimed and the amount of PIP benefits awarded or recovered in the arbitration proceeding. The amount recovered in the arbitration proceeding shall include any past due amounts paid by the insurer after commencement of the arbitration process. The numerator shall be the amount of PIP benefits recovered and the denominator shall be the amount of PIP benefits claimed in the Notice to Insurer of Amount Claimed. The percentage resulting from this comparison shall be the degree by which the insured was successful, and such percentage shall be multiplied by the amount of actual reasonable attorneys' fees determined by the arbitrators to have been incurred by the claimant. Treble damages and interest, if awarded, are not to be used as part of this calculation.

    b. The arbitrators may modify the award of attorneys' fees as set forth in P. 1 .a. above after considering the amount and timing of any written settlement offers made by any party as compared with the amount as set forth in the Notice to Insurer of Amount Claimed. However, this modification determination, if any, shall only be made after the arbitrators have first determined the amount of PIP benefits awarded and payable, if any. No written settlement offer(s) shall be provided to the arbitrators and no arguments shall be made about modification of attorneys' fees due to such settlement offers until after the arbitrators have determined the amount of benefits awarded and payable. If the arbitrators take the case under advisement and do not enter an award at the time of the arbitration hearing, then the settlement offers, if any, shall not be provided to the arbitrators until after the arbitrators' initial award is entered.

2. The arbitrators may award reasonable attorneys' fees to the insurer if the arbitrators find that the action was prosecuted by the claimant without substantial justification. If the arbitrators have decided that the action was prosecuted without substantial justification, then the amount of reasonable attorney's fees incurred by the insurer shall be provided to the arbitrators and the opposing parties by affidavit of the insurer's attorney upon the arbitrators' request at or after the arbitration hearing.

3. In no event shall the arbitrators enter an award of attorney's fees to the claimant or to the insurer which are in excess of actual reasonable attorney's fees.

Q. CHANGE OF AWARD BY ARBITRATORS

1. In addition to modifications under P.1.b. and P.2., the arbitrators may modify or correct the award where:

   a. There was an evident miscalculation of amounts or an evident mistake in the description of any person, thing, or property referred to in the award;

   b. The arbitrators made an award upon a matter not submitted to them, and the award may be corrected without affecting the merits of the decision upon the issues submitted; and/or

   c. The award is imperfect in a matter of form, not affecting the merits of the controversy.

2. A motion for correction or modification shall be made within seven business days after movant's receipt of the award or modified award. A party opposing the motion for modification or clarification shall file with the arbitrators and serve on all other parties written opposition to the motion no later than seven business days after receipt of the motion. Any correction or modification of the award must be accomplished, filed and delivered to the parties and their attorneys within ten business days after the filing of the original arbitrators' award. If modified or corrected, the modified or corrected award supersedes the original award.

R. FINALITY OF THE AWARD--JUDGMENT

Unless modified, corrected or vacated pursuant to sections P. or Q. of these rules or provisions of § 13-22-201, C.R.S., et seq.. the decision of the arbitrators shall be final. The final award may be confirmed and converted to a judgment in accordance with § § 13-22-213 and 216, C.R.S.

S. FORMS

Advisory forms for use in cases subject to these rules are attached. Reproduction of the forms is authorized. Supplies will not be provided by the Colorado Division of Insurance.

Section 5 Enforcement

Noncompliance with this Regulation may result, after proper notice and hearing, in the imposition, against any insurer, of any of the sanctions made available to the Commissioner in the Colorado Insurance Laws which includes, but is not limited to: fines, cease and desist orders, and suspension and/or revocation of a license or certificate of authority.

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 shall not be affected thereby.

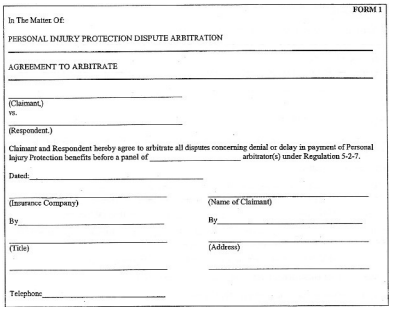
Section 7 Effective Date

This regulation is effective February 1, 2004.

Section 8 History

This regulation was originally effective November 1, 1991.

Amended Regulation 5-2-7 effective February 1, 2004.



FORM 1

In The Matter Of:

PERSONAL INJURY PROTECTION DISPUTE ARBITRATION

AGREEMENT TO ARBITRATE

(Claimant,)
vs.
(Respondent.)

Claimant and Respondent hereby agree to arbitrate all disputes concerning denial or delay in payment of Personal Injury Protection benefits before a panel of _____ arbitrator(s) under Regulation 5-2-7.

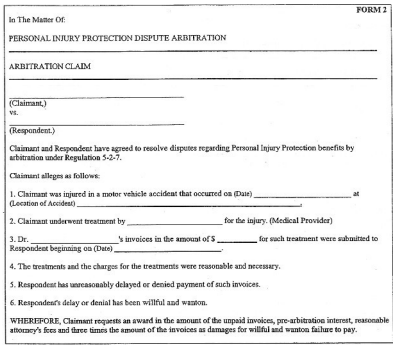
Dated: _____

(Insurance Company) — (Name of Claimant)

By _____ — By _____

(Title) — (Address)

Telephone: _____



FORM 2

In The Matter Of:

PERSONAL INJURY PROTECTION DISPUTE ARBITRATION

ARBITRATION CLAIM

(Claimant,)
vs.
(Respondent.)

Claimant and Respondent have agreed to resolve disputes regarding Personal Injury Protection benefits by arbitration under Regulation 5-2-7.

Claimant alleges as follows:

1. Claimant was injured in a motor vehicle accident that occurred on (Date) _____ at (Location of Accident) _____.

2. Claimant underwent treatment by _____ for the injury. (Medical Provider)

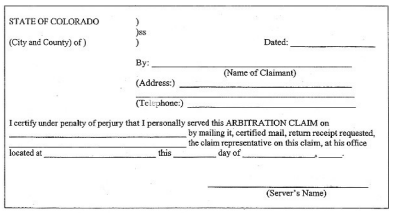
3. Dr. _____'s invoices in the amount of $ _____ for such treatment were submitted to Respondent beginning on (Date) _____.

4. The treatments and the charges for the treatments were reasonable and necessary.

5. Respondent has unreasonably delayed or denied payment of such invoices.

6. Respondent's delay or denial has been willful and wanton.

WHEREFORE, Claimant requests an award in the amount of the unpaid invoices, pre-arbitration interest, reasonable attorney's fees and three times the amount of the invoices as damages for willful and wanton failure to pay.



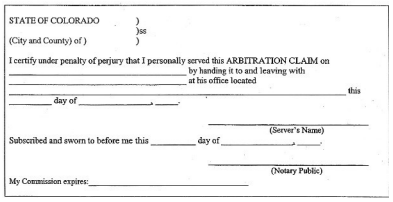
STATE OF COLORADO)
)ss
(City and County) of) Dated: _____

By: _____
(Name of Claimant)
(Address:) _____
(Telephone:) _____

I certify under penalty of perjury that I personally served this ARBITRATION CLAIM on _____ by mailing it, certified mail, return receipt requested, _____ the claim representative on this claim, at his office located at _____ this _____ day of _____, ____.

_____
(Server's Name)

OR



STATE OF COLORADO)
)ss
(City and County) of)

I certify under penalty of perjury that I personally served this ARBITRATION CLAIM on _____ by handing it to and leaving with _____ at his office located _____ this _____ day of _____, ____.

_____
(Server's Name)

Subscribed and sworn to before me this _____ day of _____, ____.

_____
(Notary Public)

My Commission expires: _____

FORM 3

In The Matter Of:

PERSONAL INJURY PROTECTION DISPUTE ARBITRATION

Date of Notice to Insurer of Amount Claimed _____

OATH OF ARBITRATORS/DISCLOSURE

_____
(Claimant,)
vs.
_____
(Respondent.)

I solemnly swear or affirm under penalty of perjury that I meet the requirements of § 13-71-109, C.R.S., to serve as a juror in this state, that I will be completely impartial, and that I will fairly and justly determine the issues placed before me.

I further swear or affirm that I have no financial or personal interest in the outcome of the arbitration of this case, except

_____
_____
_____
_____

and have no existing or past financial, business, professional, family or social relationships with any of the parties or their attorneys that will affect my impartiality or create an appearance of partiality or bias, except

_____
_____
_____
_____
_____

(Date) _____ (Signature) _____

FORM 4

In The Matter Of:

PERSONAL INJURY PROTECTION DISPUTE ARBITRATION

Date of Arbitration Claim _____

REQUEST FOR HEARING

_____
(Claimant,)
vs.
_____
(Respondent.)

Claimant requests that this matter proceed to the Arbitration Hearing to be held within 60 days after the date of service of this Request.

Dated:_____

_____
(Name of Claimant)

By: _____
_____
_____
(Telephone) _____

CERTIFICATE OF SERVICE

I certify that a true and complete copy of this REQUEST FOR HEARING was served on Respondent, the Commissioner of Insurance, and each of the arbitrators by regular mail, addressed as follows:

NAME: _____
ADDRESS: _____
CITY/STATE/ZIP CODE: _____
ATTORNEYS FOR INSURANCE COMPANY

NAME: _____
ADDRESS: _____
CITY/STATE/ZIP CODE: _____
ARBITRATOR

NAME: _____
ADDRESS: _____
CITY/STATE/ZIP CODE: _____
ARBITRATOR

NAME: _____
ADDRESS: _____
CITY/STATE/ZIP CODE: _____
ARBITRATOR

_____
(Secretary)
_____
(Date)

FORM 5

In The Matter Of:

PERSONAL INJURY PROTECTION DISPUTE ARBITRATION

Date of Arbitration Claim _____

NOTICE TO INSURER OF AMOUNT CLAIMED

_____
(Claimant,)
vs.
_____
(Respondent.)

Claimant submits to the Respondent this Notice to Insurer of Amount Claimed.

The insured claims that the amount of benefits denied by the Respondent relating to the invoices of Dr. _____ is $ _____ from _____ to _____.
(Each doctor or health care provider should be designated by a separate provision.)

The insured claims that the amount of benefits not timely paid by the Respondent relating to the invoices of Dr. _____ is $ _____. (If Applicable.)

The amount of reasonable attorneys' fees claimed by the Claimant is $ _____, from _____ to _____, plus reasonable attorneys' fees incurred after _____ through the date of hearing. The attorneys' fees are based on an hourly rate of $ _____.

Dated:_____

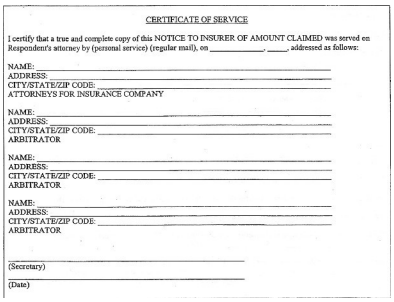
_____
(Name of Claimant)

By_____

_____
Address

_____

_____
Telephone



CERTIFICATE OF SERVICE

I certify that a true and complete copy of this NOTICE TO INSURER OF AMOUNT CLAIMED was served on Respondent's attorney by (personal service) (regular mail), on _____, _____, addressed as follows:

NAME: _____
ADDRESS: _____
CITY/STATE/ZIP CODE: _____
ATTORNEYS FOR INSURANCE COMPANY

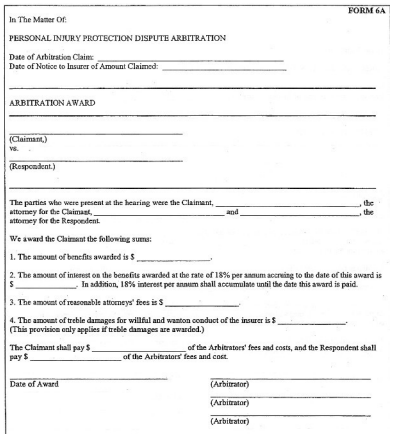
NAME: _____
ADDRESS: _____
CITY/STATE/ZIP CODE: _____
ARBITRATOR

NAME: _____
ADDRESS: _____
CITY/STATE/ZIP CODE: _____
ARBITRATOR

NAME: _____
ADDRESS: _____
CITY/STATE/ZIP CODE: _____
ARBITRATOR

_____
(Secretary)

_____
(Date)



FORM 6A

In The Matter Of:

PERSONAL INJURY PROTECTION DISPUTE ARBITRATION

Date of Arbitration Claim: _____
Date of Notice to Insurer of Amount Claimed: _____

ARBITRATION AWARD

_____
(Claimant,)
vs.
_____
(Respondent.)

The parties who were present at the hearing were the Claimant, _____, the attorney for the Claimant, _____ and _____, the attorney for the Respondent.

We award the Claimant the following sums:

1. The amount of benefits awarded is $ _____.

2. The amount of interest on the benefits awarded at the rate of 18% per annum accruing to the date of this award is $ _____. In addition, 18% interest per annum shall accumulate until the date this award is paid.

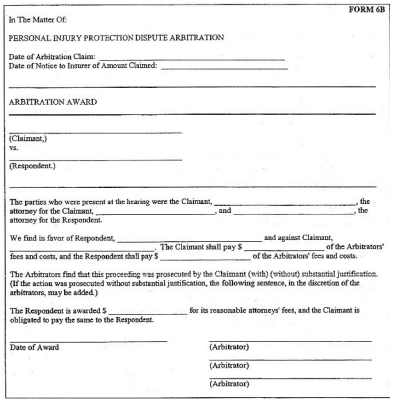
3. The amount of reasonable attorneys' fees is $ _____.

4. The amount of treble damages for willful and wanton conduct of the insurer is $ _____.
(This provision only applies if treble damages are awarded.)

The Claimant shall pay $ _____ of the Arbitrators' fees and costs, and the Respondent shall pay $ _____ of the Arbitrators' fees and cost.

_____
Date of Award

_____
(Arbitrator)
_____
(Arbitrator)
_____
(Arbitrator)



FORM 6B

In The Matter Of:

PERSONAL INJURY PROTECTION DISPUTE ARBITRATION

Date of Arbitration Claim: _____
Date of Notice to Insurer of Amount Claimed: _____

ARBITRATION AWARD

_____
(Claimant,)
vs.
_____
(Respondent.)

The parties who were present at the hearing were the Claimant, _____, the attorney for the Claimant, _____, and _____, the attorney for the Respondent.

We find in favor of Respondent, _____ and against Claimant, _____. The Claimant shall pay $ _____ of the Arbitrators' fees and costs, and the Respondent shall pay $ _____ of the Arbitrators' fees and costs.

The Arbitrators find that this proceeding was prosecuted by the Claimant (with) (without) substantial justification. (If the action was prosecuted without substantial justification, the following sentence, in the discretion of the arbitrators, may be added.)

The Respondent is awarded $ _____ for its reasonable attorneys' fees, and the Claimant is obligated to pay the same to the Respondent.

_____
Date of Award

_____
(Arbitrator)
_____
(Arbitrator)
_____
(Arbitrator)

Amended Regulation 5-2-8 Timely Payment of Personal Injury Protection Benefits

Section 1. Authority

Section 2. Background And Purpose

Section 3. Applicability and Scope

Section 4. Rules

Section 5. Enforcement

Section 6. Severability

Section 7. Effective Date

Section 8. History

Section 1 . Authority

This regulation is jointly promulgated by the Commissioner of Insurance and the Executive Director of the Department of Revenue 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.

Section 2 . Background And Purpose

The purpose of this regulation is to provide rules for the prompt investigation and timely payment of personal injury protection (PIP) benefits. 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.

This regulation is not intended to define reasonable and necessary expenses as such terminology is used in the Act.

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 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 . Rule

A. PROMPT INVESTIGATION OF PIP CLAIMS

Section § 10-3-1104 (l)(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.

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 me injury.

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.

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

Section § 10-4-708(1), C.R.S. provides that benefits under the coverages enumerated hi § 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.

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 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. Essential Service Benefits

In the usual case, if the claimant is pursuing covered PIP essential services benefits, the following documents are sufficient to establish proof of the fact and amount of essential services expenses 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 essential services as a result of the injury; and

c. A statement or billing notice for services rendered indicating:

(1) Actual services rendered;

(2) Dates of services;

(3) Amounts charged; and

(4) The name and address of the individual or entity performing the services.

4. 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

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. 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

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

1. 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 <u>solely</u> on any of the following:

a. 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

b. 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 hot 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.

2. 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 PEP 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 . Enforcement

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of any lawful sanctions including the imposition of fines and suspension or revocation of license.

Section 6 . Severability

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

Section 7 . Effective Date

This amended regulation is effective on February 1, 2004.

Section 8 . History

Issued as Regulation 5-2-8, effective November 1, 1997.

Amended effective September 1, 2000.

Amended effective February 1, 2004.

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 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 TRANSITION FROM NO-FAULT AUTO TO TORT SYSTEM [Eff. 01/01/2009]

Section 1 Authority

This regulation is promulgated pursuant to § § 10-1-109, and 10-4-601.5 (as codified in HB 03-1188 effective July 1, 2003).

Section 2 Scope and Purpose

The purpose of this regulation is to promote a smooth transition from a no-fault auto system to a tort system in the State of Colorado, by prescribing rules and providing guidance to auto insurers. On July 1, 2003, the Colorado Auto Accident Reparations Act, also known as the motor vehicle no-fault insurance law, is repealed pursuant to § 10-4-726, C.R.S. There is considerable industry and consumer confusion concerning the effect of the conversion to a tort system on auto policies. Among other things, confusion exists concerning the effect of the conversion on auto policies issued or renewed prior to July 1, 2003 that renew after July 1, 2003. In addition, there is industry confusion concerning various rate filing requirements, notice requirements regarding changes to automobile policies, and the applicability of statutory requirements to motorcycles.

Regarding the provisions of this regulation that address medical payments coverage, the purpose for the regulation is to encourage orderly and timely coordination and payment of claims, and to discourage duplicative payments under multiple available coverages and policies, including secondary health insurance policies.

The Division bases its interpretation of various statutory changes effected by the repeal of the no-fault law and the enactment of HB 03-1188 and SB 03-239 upon the constitutional prohibition against impairment of existing contracts and retrospective application of laws. These prohibitions are set forth in Article II, Section 11 of the Colorado Constitution and are elaborated upon in case law.

Section 3 Applicability

This regulation shall apply to all carriers who issue automobile policies in the State of Colorado.

Section 4 Definitions

As used in this regulation:

A. "Medical Payments Coverage" refers to automobile insurance coverage that pays for covered medical expenses incurred for bodily injury caused by an automobile accident and sustained by an insured regardless of fault.

B. "No-fault" refers to the Colorado Auto Accident Reparations Act enacted under § § 10-4-701 to 10-4-726, C.R.S. which was repealed in accordance with § 10-4-726, C.R.S. on July 1, 2003.

C. "Primary coverage" refers to a plan that provides benefits up to the limits of the policy, regardless of other insurance policies in effect. Primary coverage provides first dollar coverage regardless of whether excess or secondary coverage has been exhausted.

D. "Secondary coverage" refers to a plan that provides benefits that are not primary.

E. "Tort" refers to the auto system to which Colorado will revert on July 1, 2003. Tort refers to a civil wrong for which an insured may seek redress in a court of law, usually in the form of damages.

Section 5 Rules

A. By operation of law, Colorado will revert from a no-fault auto system to a tort system effective on July 1, 2003. The change will occur after midnight at 12:00.01 am United States mountain time, July 1, 2003, as calculated under § 2-4-109, C.R.S.

B. All auto policies issued, written or delivered on or after July 1, 2003 must be issued, written or delivered as tort policies.

C. Renewal notices delivered to insureds prior to July 1, 2003 for policies with an effective date on or after July 1, 2003, must renew or amend the policies as tort policies that comply with Part 6 of Article 4 of Title 10, and any and all other applicable insurance laws.

D. Existing no-fault policies do not automatically convert to tort policies on July 1, 2003. The policy's no-fault coverages apply until the next renewal date.

E. Insurers may offer policyholders the option to "convert" their no-fault policies to tort policies effective after midnight July 1, 2003. The insurer and policyholder must mutually agree to this mid-term conversion. Insured consent may be made in the same medium in which the offer or request to convert is made, e.g., electronically. The insurer must maintain adequate proof of the insured's consent. Adequacy will be determined by the division.

F. Insurers are prohibited from requiring policyholders to convert their no-fault policies to tort policies until the next renewal date that comes after midnight July 1, 2003.

G. Policyholders may request that insurers convert their no-fault policies to tort policies for an effective date after midnight July 1, 2003. The insurer and policyholder must mutually agree to this mid-term conversion. Insured consent may be made in the same medium in which the offer or request to convert is made, e.g., electronically. The insurer must maintain adequate proof of the insured's consent. Adequacy will be determined by the division.

H. Insurers are prohibited from re-underwriting policies mid-term that convert from the no- fault to the tort system.

I. Insurers are prohibited from charging application fees or cancellation fees or other similar charges to insureds upon conversion of policies from no-fault to tort policies.

J. Insurers are prohibited from "rolling on" additional coverages such as limits of medical payments coverage that are in excess of the amount required by law without the insured's consent. Insured consent may be made in the same medium in which the offer or request to add additional coverages is made, e.g., electronically. The insurer must maintain adequate proof of the insured's consent. Adequacy will be determined by the Division. Where insurers have added additional coverages prior to the effective date of this regulation, they must obtain insured consent for the change or remove the coverage as of its effective date, recalculate premium and refund any owed premium.

K. The division has determined that the notice requirements contained in § § 10-4-110.5, 10-4-626 (as codified in HB 03-1188 effective July 1, 2003 and later renumbered as 10- 4-629), 10-4-629 (formerly codified in HB 03-1188 as 10-4-626), and 10-4-720 (effective until July 1, 2003), C.R.S., and regulations promulgated thereunder, do not apply at the first conversion of a no-fault policy to a tort policy where the sole cause for the reduction in coverage is the repeal of the no-fault law. These statutes continue to apply when it is the insurer's actions that cause the reduction in coverage, the increase in premium or the failure to renew, i.e., application of the insurer's underwriting guidelines and/or rating rules. Where the reduction in coverage occurs solely because of the effect of the repeal of the no-fault law, the insurer is not unilaterally reducing coverages. Rather, coverages are being modified by operation of law and accordingly, the notice requirements do not apply.

L. The Division has determined that the rating provisions contained in § 10-4-416, C.R.S. do not apply at the first conversion of a no-fault policy to a tort policy, where the sole cause for the decrease in coverage is the repeal of the no-fault law. This statute continues to apply when it is the insurer's action that causes the reduction in coverage, or the increase in premium, i.e., application of the insurer's underwriting guidelines and/or rating rules. Where the reduction in coverage occurs solely because of the effect of the repeal of the no-fault law, the insurer is not unilaterally reducing coverages. Rather, coverages are being modified by operation of law and accordingly, the prohibition does not apply.

M. Except as provided in section 5(N), on or before the tenth (10th) calendar day before the effective date of the change to the policy where the insurer is first converting a no-fault policy to a tort policy, the insurer shall send by first-class mail written notice of the change to the named insured at the insured's last known address. The notice shall state in clear and specific terms all of the following:

1. The proposed action to be taken, including, if the change is a change in premium or change in coverage, the amount of the premium, the type of coverage to which the premium change is applicable, the type of coverage increased or reduced, and the extent of the change in coverage,

a. In the notice, insurers shall make reasonable efforts to express the amount of any premium change as a dollar amount allocated among the various coverages,

b. If an insurer is unable to comply with section 5(M)(1)(a) within the required timeframe, the insurer shall include in the notice a statement that the allocation of the premiums for the various coverages will be identified no later than when the policy is issued. In addition, the insurer shall be prepared to justify the failure to the division to the satisfaction of the division.

c. In no event shall a policy be issued that does not clearly differentiate the premiums for the various coverages.

2. The proposed effective date of the change.

3. A statement of reasons why the change is necessary so that a person of average intelligence can understand the necessity for the change without making further inquiry. This statement shall include, at a minimum, the following:

a. An explanation of the change in law necessitating the conversion of the policy,

b. A general explanation of why various coverages are being increased or reduced, including the effect on premium.

c. Notices regarding the changes in coverages and the changes in premiums may be mailed separately within the required timeframe.

N. Where the insured requests that the carrier convert the policy mid-term, and the insurer agrees to convert the policy, insurers shall mail the notice to the insured as required in section 5(M) or within 10 calendar days after the change becomes effective, or shall provide the same information required in section 5(M) in the same medium in which the request was made. The insurer must maintain adequate proof that the information was provided. Adequacy will be determined by the Division.

O. Motorcycles are required to have complying policies as that term is defined by § 10-4- 601(1), C.R.S. (HB 03-1188). The Colorado general assembly expressed its intent to continue the complying policy requirement for motorcycles in SB 03-239. The governor signed SB 03-239 into law on June 5, 2003, after the effective date of HB 03-1188. Accordingly, the language in SB 03-239 controls over that in HB 03-1188. SB 03-239 states in § 42-4-1409, C.R.S. that motor vehicles must have complying policies. The language clarifies that this requirement must be met “as required by law” . The language in HB 03-1188 stated the requirement had to be met in accordance with article 6 of title 10, which appears to exclude motorcycles from the definition of “motor vehicle” . This apparent conflict was resolved by SB 03-239, which now permits the division to adopt the definition of “motor vehicle” and “motorcycle” contained in title 42 for purposes of interpreting and enforcing the legislative intent in § 42-4-1409, C.R.S. (SB 03-279). For these reasons, among others, it is the division's interpretation of the relevant statutes that motorcycles must maintain complying policies.

P. Medical payments coverage shall be primary coverage unless rejected by the insured in writing or in the same medium in which the application for the policy was taken.

Q. For covered benefits and up to the policy limits, medical payments coverage includes any and all co-payments, co-insurance and deductibles of secondary plans.

Section 6 Enforcement

Noncompliance with the requirements and timeframes specified in this regulation may result, after proper notice and hearing, in the imposition of any sanctions made available in 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 suspension or revocation of license.

Section 7 Severability

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

Section 8 Effective Date

This regulation is effective January 1, 2009.

Section 9 History

Emergency regulation 03-E-1 effective from May 23, 2003 to June 3, 2003.

Emergency regulation 03-E-2 effective from June 3, 2003 to July 23, 2003.

Emergency regulation 03-E-5 effective July 23, 2003 to October 19, 2003.

Emergency regulation 03-E-10 effective October 19, 2003 to January 1, 2004.

New regulation effective on January 1, 2004.

Emergency regulation 03-E-13 effective January 1, 2004 to January 20, 2004.

Emergency regulation 04-E-1 effective January 20, 2004 to April 1, 2004.

Amended regulation effective April 1, 2004.

Amended regulation effective January 1, 2009.

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 July 1, 2003, 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 the definition found in § 10-4-601(2), C.R.S.

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

C. "Motor vehicle conviction" means 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. "Week" means any seven (7) consecutive calendar days.

E . "Prominently display" means 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.

F. "Quarterly premium payment" means 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.

G. "Usage based insurance" means 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.

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 mailed 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. Basis for refusal to write a policy of automobile insurance.

a. Colorado law prohibits discrimination solely based on age, color, sex, national origin, residence, marital status, or lawful occupation, including military service. Prohibited underwriting or rating practices may not be used in combination with any other practice when use of the prohibited practice results in a rejection, cancellation , nonrenewal, reclassification or reduction in coverage which would not have occurred but for the prohibited practice. It is also prohibited to refuse to write a policy of insurance affording the coverages required by § 10-4-620, C.R.S., solely because another insurer has canceled a policy or refused to write or renew such policy. In addition, it is prohibited to make, or permit to be made, any classification solely on the basis of 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.

b. Unless actuarial justification in support of the insurer's action has been filed with the Division of Insurance, insurers shall not refuse to write a policy for new applicants, surcharge premiums of new applicants or place new applicants in higher priced programs or plans solely based on:

(1) The fact that the applicant had no prior insurance;

(2) The identity of the applicant's prior insurer; or

(3) The applicant's prior type of coverage, including assigned risk or residual market coverage or any plan other than a preferred plan.

c. In no event shall an insurer refuse to write, surcharge, or place an applicant in a higher priced program or plan if the applicant was not required to have insurance

under § 10-4-619, C.R.S.

d. Pursuant to § 10-4-621(3), C.R.S., no insurer shall refuse to write, cancel or nonrenew, surcharge, or place an applicant in a higher priced program or plan solely on the basis that the applicant's prior limit of liability was the minimum limit of liability required by § 10-4-619, C.R.S.

e. No insurer shall refuse to write, cancel, fail to renew, reclassify an insured under, reduce coverage under (except as part of a general reduction in coverage filed with the Commissioner), or increase the premium for any complying policy as defined in § 10-4-601(1), C.R.S., based on claims paid under comprehensive coverage, unless the insurer can demonstrate that the loss was a result of an insured's actions.

f. Under § 10-4-628(3), C.R.S., an insured is entitled to protest an insurer's action pursuant to § 10-4-629, C.R.S. if the insured believes that the provisions of § 10-4-628(1)(a) or (b), C.R.S. have been violated. Insurers taking any actions subject to the provisions of §10-4-628(1)(a) or (b), C.R.S. shall:

(1) Send a notice as required by §10-4-629, C.R.S.;

(2) Include all necessary information in the notice as required by §10-4-629, C.R.S. and this regulation; and

(3) Offer the right to protest the proposed action and request a hearing thereon before the Commissioner regardless of the length of time the policy has been in effect.

2. Notice of proposed actions.

a. A proposal to cancel, nonrenew, increase the premium or reduce coverage under a private passenger motor vehicle insurance policy shall state the actual reason for proposing such action in the notice required by § 10-4-629(2)(c), C.R.S. Only one notice is required to be sent, in triplicate, to the insured at the insured's last known address. The notice required by § 10-4-629(2)(c), C.R.S. shall be separate and distinct from any other information delivered to the insured, including but not limited to the renewal notice. The date of the mailing shall be clearly identifiable on the first page of the notice. The statement of reasons shall be clear and specific so that a reasonable person can understand it. The insurer shall clearly describe or quote its underwriting rule, policy or guideline which is the basis for the proposed action. A simple recitation of dates and incidents, without further detail, is not acceptable and may cause the insurer's proposed action to be disallowed.

b. Insurers proposing to cancel, nonrenew, increase premium or reduce coverage shall, set apart and prominently display as the first sentence of the "Your Right to Protest" paragraph the insured's ability to protest the insurers action by mailing two complete copies of the notice to the Division of Insurance within ten (10) calendar days of receipt of said notice.

c. Insurers proposing to cancel, nonrenew, increase premium or reduce coverage shall prominently display on the notice form, within or adjoining the paragraph entitled "Your Right to Protest" , the following premium payment instructions:

In order to continue your coverage during the period the proposed action is

protested, you must continue to make payments according to your current premium payment plan until a final decision is made by the commissioner. You may contact your producer (agent) or the company at (phone number) for further information. Please note that the company may bill you later for any premium difference occurring if the company's action is upheld. This is the only notification you will receive to pay the premium due to continue coverage. If the premium is not paid prior to the effective date of the action listed on the notice, the coverage will lapse.

The insurer shall accept an insured's payment provided such payment is in accordance with the current premium payment plan.

d. Upon receipt by the insurer of a notice of protest regarding a proposed action of cancellation or nonrenewal, the insurer shall promptly provide the insured, with a copy to the Division of Insurance, evidence of insurance continuing through twenty (20) calendar days after the entry of a final agency order.

e. The insurer shall fax, email or postmark its response to a Division request for information within fourteen (14) calendar days of said request. A complete copy of the response, including the documentation, except documentation subject to paragraph g of this section 5.B.2., shall be forwarded to the insured . Information received by the Division and not forwarded to the insured is considered *ex parte* communication and shall not be considered during the review by the Hearing Officer.

f. The fact that an insured has requested a hearing, and the insurer has been upheld, 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. In the event the insured has requested a formal hearing, the insurer shall accept a duly signed exclusion offer which is received by the insurer either 1) prior to the effective date of the action as set forth on the notice of premium increase, cancellation or nonrenewal, or 2) within twenty (20) calendar days after the date of the Final Agency Order.

g. In the event the proposed action is protested, a complete copy of the underwriting rules or guidelines, including exceptions to the rules or guidelines, shall be furnished to the Division of Insurance in response to a request for such rules or guidelines. Partial submission of rules or guidelines without the exceptions is not acceptable. Other than the information stated on the protest notice, underwriting rules, guidelines and exceptions required under this section shall be confidential.

h. In lieu of providing a copy of the underwriting rules or guidelines for each protest, an insurer may maintain a complete copy of its underwriting rules or guidelines, including exceptions to the rules or guidelines, with the hearing officer. The company shall be responsible for providing the hearing officer with current updates of any changes to the underwriting rules or guidelines. Rules or guidelines on file with the hearing officer, at the time of the hearing, will be the basis for the hearing officer's initial decision.

i. For the purposes of this Section 5.B.2 a notice of proposed 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 proposed action is required.

3. Application of time limitations.

In reviewing protests under § 10-4-629, C.R.S., the Division of Insurance will apply the following time limitations:

a. If the insurer bases its action upon the fact that an insured has been involved in an accident which resulted in payment under the policy and/or has been convicted of a motor vehicle violation, the insurer may base its action on convictions or accidents which occurred during the thirty-six (36) month period immediately preceding the date of the proposed 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 proposed 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. In accordance with § 10-4-629 (2), (6) and (7), C.R.S., receipt of a notice of protest stays the insurer's action until the effective date of the action or twenty (20) calendar days from the date of the Commissioner's final determination, whichever is later. The final determination is issued in the form of a Final Agency Order.

d. For the purposes of Section 5.B.3.c. any general rate increase filed with the Division shall not be included in the action to be stayed.

4. Basis for cancellation of an automobile insurance policy.

a. Except in the case of a renewal policy, an insurer may cancel a policy that has been in effect less than sixty (60) calendar days at the time notice of cancellation is mailed or delivered 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. 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.

b. In the case of policies which have been in effect for more than sixty (60) calendar days, an insurer may cancel a policy affording the coverages required by § 10-4-620, C.R.S., only if the cancellation is based upon one of the following reasons:

(1) Nonpayment of premium (§ 10-4-602 (1)(a), C.R.S.); or

(2) The driver's license or motor vehicle registration of either the named insured or any operator either residing in the insured's household, or who customarily operates an automobile insured under the policy, has been under suspension or revocation during the policy period, or if the policy is a renewal, during its policy period or the 180 calendar days immediately preceding its effective date (§ 10-4-602 (1)(b), C.R.S.); or

(3) The applicant knowingly made a false statement on the application for insurance (§ 10-4-602(1)(c), C.R.S.); or

(4) The insured knowingly and willfully made a false material statement on a claim submitted under the policy (§ 10-4-602(1)(d), C.R.S.).

c. 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.

d. 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.

5. Unacceptable reasons for refusal to renew a policy of automobile insurance include, but are not limited to the following:

a. Colorado law prohibits discrimination solely based on age, color, sex, national origin, residence, marital status, or lawful occupation, including military service. Prohibited underwriting or rating practices may not be used in combination with any other practice when use of the prohibited practice results in a rejection, cancellation, nonrenewal, reclassification, or reduction in coverage, which would not have occurred but for the prohibited practice. It is also prohibited to refuse to write a policy of insurance affording the coverages required by §-10-4-620, C.R.S., solely because another insurer has canceled a policy, or refused to write or renew such policy. In addition, it is prohibited to make or permit to be made any classification solely on the basis of 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 a blind person owns the vehicle.

b. The previous producer no longer represents the company.

c. 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 protest 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.

d. Motor vehicle citations without convictions.

e. Motor vehicle convictions, which result in less than seven (7) points being assessed under the point system schedule set forth in § 42-2-127(5), C.R.S., received while in the course of employment while driving a motor vehicle used primarily as a public or livery conveyance or licensed as a commercial vehicle as described in § 10-4-627, C.R.S.

f. Payments made by insurers without a good faith reasonable investigation to determine "fault" , unless the insured has admitted the reported accident was his fault and the evidence of admission of fault is provided. A reasonable fault investigation to support the insurer's proposed 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.

g. The use of comprehensive, towing and labor, medical payments or uninsured motorist coverage claims.

h. 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.

i. 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 h and i, a conviction, accident, or payment made for the same occurrence shall be considered as one incident.

6. Unacceptable reasons for an increase in premium (other than a general increase filed with the Commissioner of Insurance) due to a reclassification of the insured under a complying policy include, but are not necessarily limited to the following:

a. The use of reasons under 1 and 5, except 5 h and i above.

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.

7. Unacceptable reasons for a reduction in coverage (other than a general reduction in coverage approved by the Commissioner of Insurance) under a complying policy include, but are not necessarily limited to the following:

a. The use of reasons under 1 and 5 above.

b. The use of any comprehensive claims.

Section 6 Enforcement

Noncompliance with this regulation may result, after notice and hearing, in the imposition of any lawful sanction including the imposition of fines and suspension or revocation of license.

Section 7 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 shall not be affected thereby.

Section 8 Effective Date

This regulation is effective January 1, 2011 .

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.

Regulation 5-2-13 Automobile Insurance Coverage For U.S. Military Personnel Called To Active Duty

Section 1 Authority

This regulation is promulgated pursuant to § § 10-1-109, 10-3-1110, 10-4-404, and 10-4-601.5, C.R.S.

Section 2 Background And Purpose

The purpose of this regulation is to ensure that members of the Armed Forces deployed or called to active duty in service of our country retain access to affordable automobile insurance coverage and are treated fairly by automobile insurers. U.S. servicemen and women usually terminate their automobile insurance or allow their policies to lapse upon deployment or call to active duty. Unfortunately, the Division has been informed that when their tour of duty ends, some insurers refuse to reinstate their policy, refuse to issue a new policy or increase their premiums on the basis they had no prior insurance.

Underwriting criteria that considers whether an applicant had prior insurance is often appropriate when issuing automobile insurance policies. However, it is not fair to apply this criteria to military personnel deployed or called to active duty who risk their lives in service of our country. The Commissioner of Insurance finds that to penalize servicemen and women in this manner is contrary to public policy.

Section 3 Applicability And Scope

This regulation shall apply to all carriers who issue automobile insurance policies in the State of Colorado .

Section 4 Definitions

The definitions in § 10-4-601, C.R.S. shall apply to this regulation.

Section 5 Rules

A. Insurers issuing automobile insurance policies covering members of the U.S. Armed Forces shall not unilaterally reduce or cancel coverage due to the covered person's failure to maintain coverage during the period the covered person is deployed or called to active duty in the U.S. military.

B. Insurers issuing automobile insurance policies covering members of the U.S. Armed Forces where the covered person is deployed or called to active duty shall not refuse to issue, reinstate or renew the policy, or a substantially similar policy, upon the covered person's return from duty, on the grounds the covered person had no prior insurance.

C. Insurers issuing automobile insurance policies covering members of the U.S. Armed Forces where the covered person is deployed or called to active duty shall not surcharge a newly issued, reinstated or renewed policy upon the covered person's return from duty on the grounds the covered person had no prior insurance.

D. Insurers issuing automobile insurance policies covering members of the U.S. Armed Forces where the covered person is deployed or called to active duty shall treat any newly issued, reinstated or renewed policy as being continuously in effect regarding rating of the policy. For example, among other things, insurers shall not remove longevity discounts on such policies, or place covered persons in more expensive tiers where the reason for the "lapse" in coverage was the covered person's call to active duty in the U.S. military.

E. Insurers may impose reasonable requirements, policies and procedures upon covered persons to verify the fact and duration of the relevant period of military service.

F. Failure to comply with the provisions of this regulation constitutes an unfair or deceptive act or practice in the business of insurance pursuant to § 10-3-1104, C.R.S.

Section 6 Enforcement

Noncompliance with the requirements and timeframes specified in this regulation may result, after proper notice and hearing, in the imposition of any sanctions made available in 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 suspension or revocation of license.

Section 7 Severability

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

Section 8 Effective Date

- Emergency Regulation 04-E-2 was effective May 25, 2004.

- This regulation is effective September 30, 2004.

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 Basis 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 and Scope

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

Section 4 Definitions

A. Total Loss: 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: Method of determining the worth of property that has been lost or damaged.

C. Third-Party Claimant: 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: 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.

(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 an offer has been tendered in compliance with § 10-3-1104 (1) (h) C.R.S.

(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 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 including the imposition of fines and/or suspension or revocation of a license.

Section 7 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.

Section 8 Effective Date

This regulation shall be effective December 1, 2004.

Section 9 History

Original regulation issued effective December 1, 2004

Regulation 5-2-16 DISCLOSURE REQUIREMENTS FOR PRIVATE PASSENGER AUTOMOBILE POLICIES [Eff. 1/01/2009]

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, 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. "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.

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

D. "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.

E. "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.

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 (C)(1) above may be satisfied by including the information in the Declarations page of the policy or in a separate disclosure form.

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, 2009.

Section 9 History

New regulation effective January 1, 2007.

Amended regulation effective January 1, 2008.

Amended regulation effective January 1, 2009.

COLORADO PRIVATE PASSENGER AUTOMOBILE INSURANCE SUMMARY DISCLOSURE FORM [Eff. 1/01/2009]

This summary disclosure form is a basic guide to the major coverages and exclusions in your policy. It is only a general description and not a statement of contract or 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 includes, but is not limited to, information on the method your insurer uses to calculate your unearned premium (e.g., pro rata or short rate), if you should cancel your policy mid-term or before

the next renewal. This summary disclosure form also provides the factors considered for cancellation, nonrenewal and increase-in-premium. These factors are general in nature and do not represent the only reasons a policy may be terminated or changed. Please contact your agent or insurer for further information. See the information on the attached pages.

I. REQUIRED COVERAGES

Colorado law requires you to carry liability coverage on your automobile.

Liability coverage pays for bodily injury to another person and for property damage to another's property caused by the negligent (at-fault) operation of your automobile up to the limits of your policy.

EXCLUSIONS - LIABILITY COVERAGE - 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. Other exclusions are listed in your policy.

II. OTHER COVERAGES

A. Uninsured and Underinsured Motorist Coverage

You must be offered uninsured and underinsured motorist coverage, and it will be included in your policy unless you reject it in writing.

Uninsured Motorist coverage pays for bodily injury that you are entitled to collect from a hit-and-run or uninsured driver who is at fault for the accident.

Underinsured Motorist coverage pays for bodily injury that you are entitled to collect from an underinsured owner or driver who is at fault for the accident and when the damages exceed the driver's liability coverage.

Generally, an underinsured automobile is an automobile whose liability coverage is not enough to pay the full amount you are legally entitled to recover as damages.

Coverage may be available under multiple policies in certain circumstances. For example, a passenger in a vehicle that is not at fault in the accident may have uninsured or underinsured coverage under the policy covering the vehicle and the passenger's own policy on their vehicle(s) not involved in the accident. This adding of limits under two or more policies is commonly referred to as stacking.

Please consult your agent or insurer if you have any questions or for further details.

EXCLUSIONS - UNINSURED AND UNDERINSURED MOTORIST COVERAGE. Coverage is not provided for any insured who, without the written consent of the insurer, settles with any person or organization who may be liable for the bodily injury. Other exclusions may be listed in the policy.

B. Physical Damage Coverages – Collision and Comprehensive

You must be offered collision coverage.

Collision coverage pays for damage to your own automobile. It provides coverage when your automobile collides with another automobile or object, or 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 for which you, the insured, are responsible. Your insurer will pay for the balance of covered repairs subject to your policy provisions. A lender may require you to purchase both collision and comprehensive coverage.

EXCLUSIONS – COLLISION AND COMPREHENSIVE. 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. Additional restrictions may apply to special equipment. [The statement on special equipment should be included only if it is applicable.] Other exclusions are listed in your policy.

C. Medical Payments Coverage

Your policy provides medical payments coverage of $5,000 unless you reject it in writing, or in the same medium in which you completed the application for the policy.

Medical payments coverage pays for reasonable health care expenses incurred for bodily injury caused by an automobile accident, regardless of fault, up to the policy limits chosen by the insured.

Your insurer must prioritize payment of the medical payments coverage benefits in a manner consistent with § 10-4-635 (2) (b), C.R.S.

Medical payments coverage is primary to any health insurance coverage available to an insured when injured in an automobile accident.

Medical payments coverage applies to any coinsurance or deductible amount required to be paid by the person's health coverage plan as defined in § 10-16-102(22.5), C.R.S.

An insured that is injured in an automobile accident will not receive benefits from medical payments coverage for any medical expenses incurred as a result of an accident that is the fault of the insured unless medical payments coverage is purchased.

Read your policy to see who is a covered person under medical payments coverage.

D. Uninsured Motorist Property Damage

This is an optional coverage you can request if you do not have collision coverage on your vehicle.

1. Uninsured Motorist Property Damage (UMPD) pays for damages to your vehicle caused by an at-fault owner of an uninsured motor vehicle.

2. UMPD will not pay if the vehicles do not physically make contact.

3. UMPD only covers actual cash value of your vehicle or cost of repair or replacement, which ever is less.

III. CANCELLATION, NONRENEWAL AND INCREASE IN PREMIUM

A. Cancellation

During the first 59 days your company may cancel your policy for any reason that is not unfairly discriminatory or prohibited by law. After your policy has been in effect for more than 59 days, your company may cancel your policy for any of the following reasons:

1. Failure to pay your premium when it is due;

2. Knowingly making a false statement on your application for an automobile policy;

3. A driver's license suspension or revocation during the policy period for you, a member of your household, or any other driver who regularly uses your automobile.

B. Nonrenewal

Your company 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 negligent (at-fault) accidents;

3. Conviction of a major violation such as drunk driving or reckless driving.

C. Increase in Premium

The following factors **may** increase your premium: a premium surcharge may be added or an accident free discount removed as a result of an at-fault accident or traffic conviction.

The following conditions may increase your premium:

1. Change of garage location of the automobile;

2. Change of automobile(s) insured;

3. Addition of 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 loss suffered by an individual policyholder. A general rate increase applies to everyone in the group, not just those who had losses.

The above list of factors and conditions is not all inclusive and there may be other factors or conditions that increase your premium.

Amended Regulation 5-3-1 Workers Compensation Risk Management Regulation

Section I Authority

This regulation is promulgated under the authority of Sections 10-1-109 and 10-4-408, C.R.S.

Section 2 Basis 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 Rules

A. Definitions

1. “Anniversary date” means the annual anniversary of the date of issue of a workers compensation insurance policy as shown in the policy declaration.

2. “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.

3. “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.

4. “Re-certification date” means each annual anniversary date of the initial certification.

5. “Risk management” means the process that uses physical and human resources to prevent or reduce losses.

6. “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.

B. 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.

C. 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 4 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 5 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 shall not be affected thereby.

Section 6 Effective Date

This Regulation will be effective March 2, 2003.

Section 7 History

Issued as new regulation 91-5, effective May l, 1991

Re-codified as regulation 5-3-1, effective June l, 1992

Amended regulation 5-3-1, effective March 2, 2003.

Amended Regulation 5-3-2 Workers' Compensation Insurance Data Reporting Regulation

Section l Authority

This regulation is promulgated pursuant to Sections 10-1-109, 10-4-404, and 8-44-113, C.R.S., authorizing the commissioner to adopt rules regarding the reporting of workers' compensation claims data.

Section 2 Basis and Purpose

The purpose of this regulation is to enhance the ability of the commissioner to determine the nature and sources of workers' compensation insurance costs in this state by establishing standards for reporting of the kinds of data required to be reported by workers' compensation insurers licensed to conduct business in Colorado and Pinnacol Assurance.

Section 3 Rules

A. Definitions

1. “Basic Claim Survey” means any annual survey of randomly selected claims to provide detailed information on selected claims. Claims data is reported until closed.

2. “Statistical Agent” means an organization designated by the commissioner to gather and compile insurance statistical experience.

3. “Statistical Plan” means a system for collecting and recording claim information.

B. Powers and Duties

The commissioner may enter into agreements with any qualified data collection service corporation, association or other entity to undertake the compilation and analysis of data collected pursuant to this regulation.

C. Statistical Reporting

Every insurer licensed to transact business of workers' compensation insurance in this state, who writes at least 0.1% of the total Colorado workers' compensation premium market share, and Pinnacol Assurance shall report its statistical experience to at least one of the statistical agents designated by the commissioner. The statistical agent designated by the commissioner shall provide statistical data definitions to insurers and Pinnacol Assurance at time of survey.

D. Annual Data Reporting

At least annually, insurers and Pinnacol Assurance shall submit to surveys by a statistical agent Upon inclusion in a survey, a particular claim shall be surveyed until closed or for eight years, whichever period is shorter. In order to prevent duplication of effort, any existing sources of data may be utilized provided that the source (e.g., statistical agent or the Division of Labor and Employment) can attest to the validity and accuracy of the data it submits.

E. Basic Claim Survey

In accordance with statistical plans adopted by the commissioner, the annual survey data shall include the following elements on each claim:

I. Accident Information

a. Employee Information

(1) Name

(2) Social Security Number

(3) Date of birth

(4) Sex

(5) Marital status

(6) Occupation at time of injury (employee class code)

(7) Employment status at time of report

(8) Number of Dependents*

(9) Date of Hire*

(10) History of previous workers' compensation injuries

(a) Previous impairment rating

(b) Number of previous injuries

(11) Race

(12) Educational level

b. Employer Information

(1) Federal tax identification number

(2) SIC code*

(3) Payroll

(4) Benefit package provided (Group Health/Disability)

c. Claims Administration Information (insurer, Pinnacol Assurance)

(1) Name of carrier

(2) Insurer identification code number

(3) Policy number

(4) Policy effective date

(5) Deductible (yes/no)**

d. Accident Severity

(1) Date of injury (accident date for traumatic injury, for all others last date of injurious exposure but if not determinable then last effective day of policy if there is one or date of first report if there is no policy).

(2) Nature of injury***

(3) Part of body affected***

(4) Cause of injury or illness***

(5) Date disability began (date eligible for benefits)

(6) Zip code of injury site

(7) Source (this is a standard ANSI category but would not be included if NCCI codes are used)

e. General Information

(1) Date reported to the employer

(2) Date reported to insurer, state fund

(3) Date reported to the Division of Labor and Employment

(4) Jurisdiction (state or federal acts)

(5) Carrier claim number

(6) Report Type

(7) Department of Labor File Number

(8) Status of time of report (open, reopen or closed)

(9) Was a risk management program in place?

(10) Did injury occur because of intoxication?

(11) Did injury occur because of failure to use safety devices?

(12) Did injury occur because of a failure to obey safely rules?

2. Benefit Information

a. Payment Information

(1) Weekly wage at time of injury

(2) Other amounts (weekly) included in computing the compensation rate

(3) Date of first indemnity payment

(4) Date of closing

(5) Date the employee returns to work

b. Indemnity Payment Information

(1) Benefits paid to date by type

Temporary total

Temporary partial

Permanent partial

Scheduled

Disfigurement

Permanent total

Fatal benefits

(2) Compensation rate by type (weekly compensation payment for each indemnity type at the time the report is completed, to be completed only where a specific type indemnity payment has been made)

(3) Incurred indemnity benefits (paid plus reserves excluding vocational rehabilitation)

(4) Funeral expense (burial benefit)

(5) Method of payment (lump sum, structured settlement)

(6) Percentage of permanent impairment (identify standard used such as the American Medical Association standard)

(7) Date of maximum medical improvement (where useful and authoritatively determined)

c. Medical Benefit Information ****

(1) Designated Provider

(2) Non-Designated Provider

(3) Health care provider

(4) Payments to health care providers

(5) Description of services and identification

(6) Payments to hospitals with description of services and identification

(7) Other medical

Drugs

Prosthetic devices

Custodial care

(8) Transportation (to/from health care provider)

(9) Incurred medical

d. Vocational Rehabilitation

(1) Vocational rehabilitation

Evaluation expense

Education/retraining expense

All other expenses

(2) Incurred vocational rehabilitation

(3) Post injury wage

e. Other Benefit Information (paid amounts in dollars)

(1) Employers liability payments

(2) Employers legal expense

(3) Employees legal expense in addition to award

(4) Expert witness fees

(5) Penalties

(6) Allocated Loss Adjustment Expenses Paid

f. Benefit Offset (yes/no)

(1) Social Security

(2) Unemployment compensation

(3) Employer-provided pension benefits

g. Benefit Recoveries (dollar amounts) ****

(1) Third party recoveries (subrogation)

Product liability

Automobile liability

Other

(2) Special fund recoveries

Subsequent Injury Fund

Apportionment between carriers

Apportionment for preexisting injury

3. Attorney Involvement and Litigation *

a. Involvement of Claimant's Attorney

(1) Attorney name

(2) Attorney identification number

(3) Date of attorney retention

(4) Financial arrangement regarding fees

b. Controverted Case Information (for each level of litigation including informal proceedings, formal proceedings, administrative and judicial review)

(1) Reason for controversy

(2) Date of award

(3) Resolution

* Include these elements if they are collected by the International Association of Industrial Accident Boards and Commissioners (LAJABC) through the Basic Administrative Information System (BAIS)

** Deductible information should be provided simply as a yes/no. If amounts are required, a special survey can be done on those cases. Companies should convert to a system that provides reports including both gross and net deductible.

*** If the IAIABC is to provide this information, ANSI codes should be used. If the information will come from the National Council on Compensation Insurance (NCCI), then NCCI codes should be used.

**** Since payment reports are generally net, recoveries must be added to determine gross payments.

Section 4 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 substantial hardship on the statistical agent or insurer.

Section 5 Confidentiality

Any report of information relating to a particular claim shall be confidential and shall not be revealed by the commissioner, except that the commissioner may make compilations including this experience.

Section 6 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 7 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 shall not be affected thereby.

Section 8 Dissemination

Each insurer and Pinnacol Assurance are instructed to distribute a copy of this regulation to all personnel snagged in activities requiring knowledge of this regulation, and to instruct them as to its scope and operation.

Section 9 Effective Date

This regulation is effected March 2, 2003.

Section 10 History

Issued as new regulation 91-6, effective September l, 1991.

Re-codified as regulation 5-3-2, effective June l, 1992.

Amended regulation 5-3-2, effective March 2, 2003.

Amended Regulation 5-3-3 Concerning Workers' Compensation Deductible Policies in Excess of $5,000

Section 1 Authority

This regulation is promulgated pursuant to §10-1-109(1) and (2), C.R.S.

Section 2 Basis 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 contacts.

Section 3 Rules

For the purpose of this regulation, “large deductible policy” means a policy subject to a deductible in excess of $5,000.

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.

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 follows:

> The premium the insurer would have charged if the policy had no deductible after application of any credits or debits for experience rating, schedule rating, premium size, risk management, or employer designated medical provider.

The premium reported to the Colorado Division of Workers' Compensation, is subject to the assessment by the Major Medical Insurance Fund, the Subsequent Injury Fund, the Workers' Compensation Cash Fund and the Cost Containment Fund.

The premium for large deductible policies shall be subject to the same reporting requirements as other workers' compensation premiums subject to assessment by the Major Medical Insurance Fund, the Subsequent Injury Fund, the Workers' Compensation Cash Fund and the Cost Containment Fund.

The requirements of this regulation apply to all large deductible policies issued or renewed after the effective date of this regulation.

Section 4 Enforcement

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

Section 5 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 shall not be affected in any way.

Section 6 Effective Date

This regulation is effective March 2, 2003.

Section 7 History

New Regulation 5-3-3, effective January l, 1995.

Emergency Regulation 98-E-l, effective July l, 1998.

Amended regulation 5-3-3, effective September 28, 1998.

Amended regulation 5-3-3, effective March 2, 2003.

Amended 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 l Authority

This regulation is promulgated pursuant to Sections 10-1-109 and 10-4408 (5)(e), C.R.S.

Section 2 Basis 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 Rules

A. Not At Fault Motor Vehicles 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 beer 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

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.

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 4 Enforcement

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of all applicable 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 5 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 shall not be affected in any way.

Section 6 Effective Date

This regulation is effective March 2, 2003.

Section 7 History

Issued as new regulation, effective February l, 1995.

Amended regulation, effective March 2, 2003.

New Regulation 5-3-5 Workers' Compensation Deductible Reimbursement

Section 1 Authority

This regulation is promulgated pursuant to § § 8-44-111 and 10-1-109, C.R.S.

Section 2 Basis 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 maximum of 55,000 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 $5,003 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 and Scope

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 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 a :maximum of $5,000 per 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 employer's receive accurate experience modification factors.

However, insurers shall also report the total or full amount of the loss (without regard to the $5,000 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 5 Enforcement

Noncompliance with this regulation may result, after proper notice and hearing, in the imposition of any sanction(s) allowed by law, including, without limitation, any one or more of the following: civil penalties, fines, license suspension, or license revocation.

Section 6 Severability

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

Section 7 Effective Date

Insurers subject to this regulation shall bring their systems into compliance on or before January l, 2003. Unit statistical reports received by the statistical agent on and after January l, 2003 shall incorporate the required change.

This regulation is effective July 1, 2002.

Section 8 History

Regulation new, effective July 1, 2002.

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.

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).*