

Chapter 66.

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Subchapter 1.
General Provisions.
[Reserved.]

Subchapter 2.
Trade Practices Act.

23-66-201. Title.

This subchapter may be referred to as the "Trade Practices Act".

23-66-202. Purpose.

(a) The purpose of this subchapter is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in Pub. L. 79-15 by defining, or providing for the determination of, all practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

(b) However, no provisions of this subchapter are intended to establish or extinguish a private right of action for a violation of any provision of this subchapter.

23-66-203. Definitions.

As used in this subchapter:

(1) "Commissioner" means the Insurance Commissioner of this state;

(2)(A) "Depository institution" means a bank or savings association.

(B) The terms "depository institution" or "depository corporation" do not include an insurance company;

(3) "Insurance policy" or "insurance contract" means any contract of insurance, indemnity, medical or hospital service, suretyship, or annuity which is issued, proposed for issuance, or intended for issuance by any person; and

(4)(A) "Person" means any individual, corporation, association, partnership, reciprocal exchange, interinsurer, Lloyd's insurer, fraternal benefit society, and any other legal entity engaged in the business of insurance, including agents, brokers, and adjusters.

(B)(i) "Person" also means medical service plans and hospital service plans as defined in § 23-75-101.

(ii) For purposes of this subchapter, medical and hospital service plans shall be deemed to be engaged in the business of insurance.

23-66-204. Provisions of subchapter additional to existing law.

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

23-66-205. Unfair competition or unfair or deceptive acts or practices prohibited.

No person shall engage in this state in any trade practice which is defined in this subchapter as being, or determined pursuant to this subchapter to be, an unfair method of competition or an unfair or deceptive act or practice in the business of insurance. This subchapter shall apply to policies and contracts of surplus line insurers, as appropriate and unless the context requires otherwise.

23-66-206. Unfair methods of competition and unfair or deceptive acts or practices defined.

The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(1) "Boycott, coercion, and intimidation" are entering into any agreement to commit or, by any concerted action, committing any act of boycott, coercion, or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance;

(2) "Churning of business" is wherein the licensee replaces an existing policy of life insurance or accident and health insurance, or both, and that replacement is not in accordance with § 23-66-307 or that replacement is without objective demonstration by the licensee of the purpose of replacing the policy for the benefit and betterment of the insured;

(3) "Defamation" is making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or of any pamphlet, circular, article, or literature that is false or maliciously critical of or derogatory to the financial condition of any person and that is calculated to injure that person;

(4)(A) "Failure to maintain complaint handling procedures" is failing to adopt and implement reasonable standards for the prompt handling of complaints received by the person from insureds or claimants, or from the Insurance Commissioner on behalf of insureds or claimants, and failing to keep a record thereof.

(B) A complete complaints register of all complaints that the person has received since the date of its last examination shall be maintained. This complaints register shall indicate:

(i) The total number of complaints;

(ii) The classification of complaints by line of insurance;

(iii) The nature of each complaint;

(iv) The disposition of each complaint;

(v) The time it took to process each complaint; and

(vi) Such other information as the commissioner may reasonably require by way of regulations.

(C) For purposes of this subdivision (4), "complaint" means any written communication primarily expressing a grievance;

(5) "Failure to maintain conflict of interest procedures" is failing to adopt and implement on or before the next financial or market conduct examination conducted by the commissioner on and after passage of this act and thereafter maintain written conflict of interest procedures and provisions, in form and format satisfactory to the commissioner, designed to identify and resolve promptly any general or pecuniary conflicts of interest as to officers, directors, managers, supervisors, and other key personnel of domestic insurers, including, but not limited to, domestic stock and mutual insurers, domestic stipulated premium insurers, domestic mutual assessment life and disability insurers, domestic health maintenance organizations, domestic farmers' mutual aid associations, domestic hospital or medical service corporations, and domestic fraternal benefit societies;

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

(7) "False statements and entries" are:

(A) Filing with any supervisory or other public official or making, publishing, disseminating, circulating, or delivering to any person, or placing before the public or causing, directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public any false statement of financial condition of a person with intent to deceive; and

(B) Knowingly making any false entry of a material fact in any book, report, or statement of any person or knowingly omitting to make a true entry of any material fact pertaining to the business of the person in any book, report, or statement of that person;

(8) "Misrepresentation and false advertising of insurance policies" is making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustrations, circular, statement, sales presentation, omission, or comparison, which:

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

(B) Misrepresents the dividends or share of the surplus to be received on any insurance policy;

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

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

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

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

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

(H) Misrepresents any insurance policy as being shares of stock;

(9)(A) "Policy cancellations" are cancellations of insurance coverage on a property or casualty risk that has been in force over sixty (60) days or after the effective date of a renewal policy or an annual anniversary date unless the cancellation is based upon at least one (1) of the following reasons:

(i) Nonpayment of premium;

(ii) Fraud or material misrepresentation made by or with the knowledge of the named insured in obtaining the policy, continuing the policy, or in presenting a claim under the policy;

(iii) The occurrence of a material change in the risk that substantially increases any hazard insured against after policy issuance;

- (iv) Violation of any local fire, health, safety, building, or construction regulation or ordinances with respect to any insured property or the occupancy of the property that substantially increases any hazard insured against under the policy;
 - (v) Nonpayment of membership dues in those cases in which the bylaws, agreements, or other legal instruments of the insurer issuing the policy require payment as a condition of the issuance and maintenance of the policy; or
 - (vi) A material violation of a material provision of the policy.
- (B) Cancellations of property and casualty policies shall only be effective when notice of cancellation is mailed or delivered by the insurer to the named insured and to any lienholder or loss payee named in the policy at least twenty (20) days prior to the effective date of cancellation. However, where cancellation is for nonpayment of premium, at least ten (10) days' notice of cancellation accompanied by the reason for cancellation shall be given.
- (C) The provisions of subdivision (9) of this section shall not be applicable to any policy providing coverage for workers' compensation or employers' liability or to any policy providing coverage for personal automobile liability, automobile physical damage, or automobile collision, or any combination thereof;
- (10) "Rebates" are:
- (A) Except as otherwise expressly provided by law, defined as the act of knowingly:
 - (i) Permitting or offering to make or making any life, health, and annuity insurance contract, or agreement as to the contract, other than as plainly expressed in the insurance contract issued thereon;
 - (ii) Paying, allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to the insurance contract any rebate of premiums payable on the contract or any special favor or advantage in the dividends or other benefits thereon or any valuable consideration or inducement whatever not specified in the contract; or
 - (iii) Giving, selling, or purchasing or offering to give, sell, or purchase as inducement to the insurance contract or in connection with the contract any stocks, bonds, or other securities of any insurance company or other corporation, association, or partnership, or any dividends or profits accrued thereon or anything of value whatsoever not specified in the insurance contract; but
 - (B) Nothing in subdivisions (10)(A) or (14) of this section shall be construed as including within the definitions of discrimination or rebates any of the following practices:
 - (i) In the case of any contract of life insurance or life annuity, the paying of bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided that those bonuses or abatement of premiums shall be fair and equitable for policyholders and for the best interests of the company and its policyholders;
 - (ii) In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount that fairly represents the saving in collection expenses;
 - (iii) Readjustment of the rate of premium for a group insurance policy based on the loss or expense under the policy at the end of the first or any subsequent policy year of insurance under the policy, which may be made retroactive only for the policy year; or

(iv) Engaging in an arrangement that does not violate section 106 of the Bank Holding Company Act Amendments of 1972, 12 U.S.C. § 1972, as interpreted by the Board of Governors of the Federal Reserve System, or section 1464(q) of the Home Owners Loan Act, 12 U.S.C. § 1461 et seq.;

(11) "Stock operations and advisory board contracts" are issuing or delivering or permitting agents, officers, or employees to issue or deliver agency company stock, or other capital stock or benefit certificates or shares in any common-law corporation, or securities or any special or advisory board contracts or other contracts of any kind that promise returns and profits as an inducement to insurance;

(12) "Underwriting: refusing certain risks" is refusing to issue or limiting the amount of coverage on a property or casualty risk based upon knowledge of an insurer's nonrenewal of the applicant's previous property or casualty policy or contract;

(13) "Unfair claims settlement practices" are committing or performing with such frequency as to indicate a general business practice any of the following:

(A) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

(B) Failing to acknowledge and act reasonably and promptly upon communications with respect to claims arising under insurance policies;

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

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

(E) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

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

(G) Attempting to settle claims on the basis of an application that was altered without notice to, or knowledge or consent of, the insured;

(H) Making claim payments to policyholders or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made;

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

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

(K) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by those insureds;

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

(M) Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

(N) Failing to promptly settle claims, when liability has become reasonably clear, under one (1) portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage; and

(O) Requiring as a condition of payment of a claim that repairs must be made by a particular contractor, supplier, or repair shop;

(14) "Unfair discrimination" is:

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

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

(C) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, cancelling, or limiting the amount of insurance coverage on a property or casualty risk because of the geographic location of the risk unless:

(i) The refusal, cancellation, or limitation is for a business purpose that is not a mere pretext for unfair discrimination; or

(ii) The refusal, cancellation, or limitation is required by law or regulatory mandate;

(D) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, cancelling, or limiting the amount of insurance coverage on a residential property risk or on the personal property contained therein because of the age of the residential property unless:

(i) The refusal, cancellation, or limitation is for a business purpose that is not a mere pretext for unfair discrimination; or

(ii) The refusal, cancellation, or limitation is required by law or regulatory mandate;

(E) Refusing to insure, refusing to continue to insure, or limiting the amount of coverage available to an individual because of the marital status of the individual. However, nothing in this subdivision (14)(E) shall prohibit an insurer from taking marital status into account for the purpose of defining persons eligible for dependent benefits;

(F) Terminating or modifying coverage or refusing to issue or refusing to renew any policy or contract of insurance solely because the applicant or insured or any employee of either is mentally or physically impaired. However, this subdivision (14)(F) shall not be interpreted to modify any other provision of law relating to the termination, modification, issuance, or renewal of any insurance policy or contract; and

(G) Refusing to insure or continue to insure any individual or risks solely because of race, color, creed, national origin, citizenship, or sex; and

(15)(A) "Unfair financial planning practices" include an insurance producer:

(i)(a) Holding himself or herself out, directly or indirectly, to the public as a financial planner, investment adviser, consultant, financial counselor, or any other specialist engaged in the business of giving financial planning or advice relating to investments,

insurance, real estate, tax matters, or trust and estate matters, if the insurance producer is, in fact, engaged only in the sale of policies.

(b) However, subdivision (15)(A)(i)(a) of this section does not preclude a person who holds some form of formal recognized financial planning or consultant certification or designation from using the certification or designation when the person is only selling insurance.

(c) Subdivision (15)(A)(i)(a) of this section does not permit persons to charge an additional fee for services that are customarily associated with the solicitation, negotiation, or servicing of policies;

(ii)(a) Engaging in the business of financial planning without disclosing in writing to the client, prior to the execution of the agreement provided for in subdivision (15)(A)(iii) of this section, or solicitation of the sale of a product or service that:

(1) He or she is also an insurance salesperson; and

(2) A commission for the sale of an insurance product will be received in addition to a fee for financial planning, if the sale involves a commission.

(b) The disclosure requirement under this subdivision (15)(A)(ii) may be met by including it in any written disclosure required by federal or state securities law; and

(iii)(a)(1) Charging fees other than commissions for financial planning by an insurance producer unless the fees are based upon a written agreement that is signed by the party to be charged in advance of the performance of the services under the agreement.

(2) A copy of the agreement under subdivision (15)(A)(iii)(a)(1) of this section must be provided to the party to be charged at the time the agreement is signed by the party.

(3) The services for which the fee is to be charged must be specifically stated in the agreement.

(4) The amount of the fee to be charged or how it will be determined or calculated must be specifically stated in the agreement.

(5) The agreement must state that the client is under no obligation to purchase any insurance product through the insurance producer or financial consultant.

(iii)(b) The insurance producer shall retain a copy of the agreement for not less than three (3) years after completion of services, and a copy shall be available to the commissioner upon request.

(B) "Unfair financial planning practices" do not include funeral expense insurance and prepaid funeral benefits contracts.

23-66-207. Rules and regulations to identify prohibited methods of competition, acts, or practices.

(a) The Insurance Commissioner may, after notice and hearing, promulgate reasonable rules and regulations, as are necessary or proper to identify specific methods of competition or acts or practices which are prohibited by § 23-66-206 or § 23-66-312, but the regulations shall not enlarge upon or extend the provisions of those sections.

(b) The regulations shall be subject to review in accordance with § 23-61-307.

23-66-208. Power of commissioner to examine and investigate.

(a) The Insurance Commissioner shall have power to examine and investigate the affairs of every person engaged in the business of insurance in this state in order to determine whether the person has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice prohibited by § 23-66-205.

(b)(1) If the person engaged in the business of insurance is a depository institution, the commissioner shall have the power to examine and investigate the insurance activities of the depository institution in order to determine whether the depository institution has been or is engaged in any unfair trade practice prohibited by this subchapter.

(2) Before beginning an examination or investigation under subdivision (b)(1) of this section, the commissioner shall notify the appropriate bank regulatory agency of the commissioner's intent to examine or investigate the depository institution and shall advise the appropriate federal banking agency of the suspected violations of state law.

23-66-209. Hearings - Procedures.

(a)(1) Whenever the Insurance Commissioner has reason to believe that any person has been engaged or is engaging in this state in any unfair method of competition or any unfair or deceptive act or practice, whether or not defined in § 23-66-206 or § 23-66-312 and that a proceeding by the commissioner in respect thereto would be to the interest of the public, the commissioner shall issue and serve upon the person a statement of the charges in that respect and a notice of a hearing thereon to be held at a time and place fixed in the notice, which shall not be fewer than ten (10) days after the date of the service thereof.

(2) If the person in subdivision (a)(1) of this section is a depository institution, the commissioner shall have the power to require the depository institution to produce books, papers, records, correspondence, or other documents that the commissioner deems relevant only to an inquiry of the insurance activities of the depository institution.

(b) At the time and place fixed for the hearing, the person shall have an opportunity to be heard and to show cause why an order should not be made by the commissioner requiring such a person to cease and desist from the acts, methods, or practices so complained of. Upon good cause shown, the commissioner shall permit any person to intervene, appear, and be heard at the hearing by counsel or in person.

(c) Nothing contained in this subchapter shall require the observance at the hearing of formal rules of pleading or evidence.

(d)(1) Upon the hearing, the commissioner:

(A) May administer oaths, examine and cross-examine witnesses, and receive oral and documentary evidence; and

(B) Shall have the power to subpoena witnesses, compel their attendance, and require the production of books, papers, records, correspondence, or other documents that the commissioner deems relevant to the inquiry.

(2)(A) The commissioner may, upon the hearing, and shall, upon the request of any party, cause to be made a stenographic record of all the evidence and all the proceedings had at such a hearing.

(B) If no stenographic record is made and if a judicial review is sought, the commissioner shall prepare a statement of the evidence and proceeding for use on review.

(3) In case of a refusal of any person to comply with any subpoena issued pursuant to this subsection or to testify with respect to any matter concerning which the person may be lawfully interrogated, the Pulaski County Circuit Court or the circuit court of the county where the party resides, on application of the commissioner, may issue an order requiring the person to comply with the subpoena and to testify. Any failure to obey the order of the court may be punished by the court as a contempt thereof.

(e)(1) Statements of charges, notices, orders, and other processes of the commissioner under this subchapter may be served by anyone authorized by the commissioner, either in the manner provided by law for service of process in civil actions or by registering and mailing a copy thereof to the person affected by such a statement, notice, order, or other process at his or her or its residence or principal office or place of business.

(2) The verified return by the person so serving the statement, notice, order, or other process setting forth the manner of the service shall be proof of process, and the return postcard receipt for the statement, notice, order, or other process, registered and mailed as described in this section, shall be proof of the service of process.

23-66-210. Cease and desist and penalty orders - Modifications.

(a) If after the hearing the Insurance Commissioner shall determine that the person charged has engaged in an unfair method of competition or an unfair or deceptive act or practice, the commissioner shall reduce his or her findings to writing and shall issue and cause to be served upon the person charged with the violation a copy of the findings and an order requiring the person to cease and desist from engaging in the method of competition, act, or practice, and, if the act or practice is a violation of § 23-66-206 or § 23-66-312, the commissioner may at his or her discretion order any one (1) or more of the following:

(1) Payment of a monetary penalty of not more than one thousand dollars (\$1,000) for each and every act or violation but not to exceed an aggregate penalty of ten thousand dollars (\$10,000) unless the person knew or reasonably should have known he or she was in violation of this subchapter. In this case, the penalty shall be not more than five thousand dollars (\$5,000) for each and every act or violation but in an amount not to exceed an aggregate penalty of fifty thousand dollars (\$50,000) in any six-month period; or

(2) Suspension or revocation of the person's license, if he or she knew or reasonably should have known he or she was in violation of this chapter.

(b) Until the expiration of the time allowed under § 23-66-212(a) for filing a petition for review by appeal if no petition has been filed within the time or, if a petition for review has been filed within the time, then until the transcript of the record in the proceeding has been filed in the circuit court, as provided in § 23-66-212, the commissioner may at any time, upon such notice and in such manner as the commissioner shall deem proper, modify or set aside in whole or in part any order issued by him or her under this section.

(c) After the expiration of the time allowed for filing a petition for review if no petition has been filed within the time, the commissioner may at any time after notice and opportunity for hearing reopen and alter, modify, or set aside, in whole or in part, any order issued by him or her under this section whenever, in his or her opinion, conditions

of fact or of law have so changed as to require that action, or if the public interest shall so require.

(d) If the person who has engaged in an unfair method of competition or an unfair or deceptive act or practice under subsection (a) of this section is a depository institution, the commissioner shall:

- (1) If practicable, notify the appropriate bank regulatory agency before:
 - (A) Imposing a monetary penalty on the depository institution; or
 - (B) Suspending or revoking the depository institution's insurer's license; and
- (2) Provide to the appropriate bank regulatory agency a copy of the findings.

23-66-211. Penalty for violation of cease and desist orders.

Any person who violates a cease and desist order of the Insurance Commissioner under § 23-66-210 while the order is in effect may, after notice and hearing upon order of the commissioner, be subject at the discretion of the commissioner to any one (1) or more of the following:

- (1) A monetary penalty of not more than ten thousand dollars (\$10,000) for each and every act of violation; or
- (2) Suspension or revocation of that person's license.

23-66-212. Judicial review of cease and desist orders.

(a)(1) Any person subject to an order of the Insurance Commissioner under § 23-66-210 or § 23-66-211 may obtain a review of the order by filing in the Circuit Court of Pulaski County, within thirty (30) days from the date of the service of the order, a written petition praying that the order of the commissioner be set aside.

(2) A copy of the petition shall be immediately served upon the commissioner, and thereupon the commissioner immediately shall certify and file in the court a transcript of the entire record in the proceeding, including all the evidence taken and the report and order of the commissioner.

(3) Upon the filing of the petition and transcript, the court shall have jurisdiction of the proceeding and of the question determined therein, shall determine whether the filing of the petition shall operate as a stay of the order of the commissioner, and shall have the power to make and enter upon the pleadings, evidence, and proceedings set forth in the transcript a decree modifying, affirming, or reversing the order of the commissioner in whole or in part.

(4) The findings of the commissioner as to the facts, if supported by substantial evidence, shall be conclusive.

(b)(1) To the extent that the order of the commissioner is affirmed, the court shall thereupon issue its own order commanding obedience to the terms of the order of the commissioner.

(2) If either party shall apply to the court for leave to adduce additional evidence and shall show to the satisfaction of the court that the additional evidence is material and that there was reasonable grounds for the failure to adduce the evidence in the proceeding before the commissioner, then the court may order the additional evidence to be taken

before the commissioner and to be adduced upon the hearing in such manner and upon such terms and conditions as to the court may seem proper.

(3) The commissioner may modify his or her findings of fact or make new findings by reason of the additional evidence so taken. The commissioner shall then file the modified or new findings which shall be conclusive if supported by substantial evidence, and file his or her recommendations, if any, for the modification or setting aside of his or her original order, with the return of the additional evidence.

(c) An order issued by the commissioner under § 23-66-210 shall become final:

(1) Upon the expiration of the time allowed for filing a petition for review if no petition has been filed within the time. However, the commissioner may thereafter modify or set aside his or her order to the extent provided in § 23-66-210; or

(2) Upon the final decision of the court if the court directs that the order of the commissioner be affirmed or the petition for review dismissed.

(d) No order of the commissioner under this subchapter, or order of a court to enforce the order, shall in any way relieve or absolve any person affected by the order from any liability under any other laws of this state.

23-66-213. Judicial review by intervenor.

(a) If, after a hearing under § 23-66-210 or § 23-66-211, the report of the Insurance Commissioner does not charge a violation of this subchapter, then any intervenor in the proceedings may within thirty (30) days after the service of the report cause a petition, notice of appeal, or petition for writ of certiorari to be filed in the Chancery Court of Pulaski County for review of the report.

(b) Upon the review, the court shall have authority to issue appropriate orders and decrees in connection therewith, including, if the court finds that it is to the interest of the public, orders enjoining and restraining the continuance of any method of competition, act, or practice which it finds, notwithstanding the report of the commissioner, constitutes a violation of this subchapter and contains penalties pursuant to § 23-66-212.

23-66-214. Immunity from prosecution.

(a) If any person shall ask to be excused from attending and testifying or from producing any books, papers, records, correspondence, or other documents at any hearing on the ground that the testimony or evidence required of the person may tend to incriminate him or her or subject him or her to a penalty or forfeiture, and shall, notwithstanding, be directed to give the testimony or produce the evidence, then he or she must nonetheless comply with the direction, but he or she shall not thereafter be prosecuted or subjected to any penalty or forfeiture for or on account of any transaction, matter, or thing concerning which he or she may testify or produce evidence pursuant thereto and no testimony so given or evidence produced shall be received against him or her upon any criminal action, investigation, or proceeding.

(b) However, no individual so testifying shall be exempt from prosecution or punishment for any perjury committed by him or her while so testifying. The testimony or evidence so given or produced shall be admissible against him or her upon any criminal action, investigation, or proceeding concerning the perjury. Further, he or she shall not be

exempt from the refusal, revocation, or suspension of any license, permission, or authority conferred, or to be conferred, pursuant to the insurance law of this state.

(c) The individual may execute, acknowledge, and file in the office of the Insurance Commissioner a statement expressly waiving the immunity or privilege in respect to any transaction, matter, or thing specified in the statement. Thereupon, the testimony of the person or the evidence in relation to the transaction, matter, or thing may be received or produced before any judge or justice, court, tribunal, grand jury, or otherwise, and if so received or produced, the individual shall not be entitled to any immunity or privilege on account of any testimony he or she may so give or evidence so produced.

23-66-215. Penalty for late payment of claims by health carriers.

(a)(1) A health carrier shall pay a penalty of twelve percent (12%) per annum for late payment of claims under a health insurance contract pursuant to regulations promulgated by the Insurance Commissioner, without necessity for demand for payment by a claimant.

(2) Hiring a third-party administrator or other person to process claims shall not relieve a health carrier of its obligation to pay this penalty.

(b) For purposes of this section:

(1) "Claimant" means a person insured or covered by a health carrier, a provider holding a valid assignment from a person insured or covered by a health carrier, or a provider contracted with a health carrier, who is claiming a benefit under a health insurance contract;

(2)(A) "Health carrier" means a health maintenance organization, hospital medical service corporation, or a disability insurance company.

(B) "Health carrier" includes a self-insured governmental or church plan and third-party administrators that administer or adjust disability benefits for a disability insurer, hospital medical service corporation, health maintenance organization, self-insured governmental plan or self-insured church plan.

(C) "Health carrier" does not include:

(i) An automobile insurer paying medical or hospital benefits under § 23-89-202(1) or a self-insured employer health benefits plan; or

(ii) Any person, company, or organization licensed or registered to issue or who issues any insurance policy or insurance contract in this state as described in §§ 23-62-102 and 23-62-104 - 23-62-107 providing medical or hospital benefits for accidental injury or disability; and

(3)(A) "Health insurance contract" means a disability insurance policy, a hospital medical service corporation contract, a health maintenance organization contract, or a plan document issued or provided by a health carrier.

(B) "Health insurance contract" does not include a disability income insurance policy, a long-term care contract, a hospital indemnity contract, an accident-only contract, or any other form of disability insurance policy that provides a benefit as a result of a sickness or accident that does not directly cover expenses related to health care treatment.

Subchapter 3.

Miscellaneous Prohibited Practices.

23-66-301. Misrepresentation or false claims or proofs.

Any person shall upon conviction be punished as provided in § 23-60-108 who, knowing it to be such:

- (1) Presents or causes to be presented a false or fraudulent claim, or any false or fraudulent proof in support of a claim, for the payment of a loss under an insurance policy;
- (2) Prepares, makes, or subscribes any false or fraudulent account, certificate, report, affidavit, or proof of loss, or other document or writing, with the intent or knowledge that it will be presented or used in support of a claim under an insurance policy; or
- (3) Conceals, withholds, or misrepresents any information material to a claim under an insurance policy.

23-66-302. False representations.

Any person who makes any material false statement, representation, or pretense for the purpose of obtaining insurance business shall upon conviction be subject to the penalties provided in § 23-60-108.

23-66-303. Intimidation or coercion of business.

No person shall use intimidation or coercion as a means of securing insurance business.

23-66-304. Fictitious groups.

- (a) No insurer, whether an authorized or unauthorized insurer, shall make available through any rating plan or form any fire, casualty, or surety insurance to any person, firm, corporation, or association of individuals at any preferred rate, premium, or form of contract based upon any fictitious grouping of the firm, corporation, or association.
- (b) "Fictitious grouping" is defined and declared to be the grouping by membership, nonmembership, license, franchise, agreement, contract, or any other method or means wherein the person, firm, corporation, or association of individuals of a group may receive a preferred rate, premium, or form of insurance contract.
- (c) Nothing in this section shall apply to the State of Arkansas or any governmental unit thereof, including counties, school districts, municipalities, state agencies, or any other governmental subsidiary, to life or accident and health insurance or to annuity contracts, nor to any insurer that restricts its insurance coverage to members of a particular association or organization with which the insurer is directly affiliated.

23-66-305. Misrepresentations in application for insurance.

- (a) No agent, broker, solicitor, examining physician, or other person shall make a false or fraudulent statement or representation in, or relative to, an application for insurance.
- (b) Violations of this section shall be punishable under § 23-60-108.

23-66-306. Misrepresentation of other policies.

(a) No person shall make or issue, or cause to be made or issued, any written or oral statements misrepresenting or making incomplete comparisons regarding the terms or conditions or benefits contained in any policy or contract of insurance for the purpose of inducing or attempting to induce the owner of the policy or contract of insurance to forfeit or surrender the policy or contract or to allow it to lapse for the purpose of replacing the policy or contract with another.

(b)(1) No person shall misrepresent the benefits, advantages, conditions, or terms of a medicare supplement insurance policy, certificate, or contract of insurance, nor make or issue or cause to be made or issued, any written or oral statement misrepresenting the terms or conditions or benefits contained in any medicare supplement policy, certificate, or contract of insurance for the purpose of inducing or attempting to induce any individual to purchase coverage under the medicare supplement policy, certificate, or contract of insurance.

(2) No person shall make or issue, or cause to be made or issued, any written or oral statements misrepresenting or making incomplete comparisons regarding the terms or conditions or benefits contained in any medicare supplement insurance policy or certificate or contract of insurance for the purpose of inducing or attempting to induce the insured of the policy or certificate or contract of insurance to forfeit or surrender the policy or certificate or contract or to allow it to lapse for the purpose of replacing the policy or certificate or contract with another.

(3) Any person who violates this subsection shall upon conviction be guilty of a Class D felony and shall be punished by a fine of not more than ten thousand dollars (\$10,000) or imprisonment in the state penitentiary for not more than six (6) years, or by both fine and imprisonment.

23-66-307. Inducement to forfeit, surrender, etc., other policies.

(a)(1) It is the public policy of this state that life and accident and health insurance agents shall provide reasonable and professional service to each insured or prospective insured.

(2) Each agent is therefore charged with the responsibility of exercising discretion and good faith in the sales presentation or transaction.

(3) Further, it is within the general welfare of the people that each life and accident and health agent, when it is professionally advisable, shall improve upon or change the type of insurance that any insured or prospective insured presently has by providing either better coverage or an overall program of insurance more suitable for the needs of the insured, his or her family, or a business.

(4) However, certain abuses occur when agents engage in the above type of solicitation without good faith and professional discretion.

(b) It shall be unlawful for any agent to encourage, induce, or solicit any insured to permit a policy of permanent insurance to lapse, or otherwise forfeit or surrender those contracts or policies except in compliance with the provisions of subsection (c) of this section.

(c) Whenever any agent in a sales presentation seeks to induce the holder of any permanent life insurance policy to permit it to lapse or to surrender, forfeit, or change the existing permanent life insurance coverage, the agent shall:

(1) Furnish the policyholder a written memorandum, dated, comparing the existing and the proposed life insurance coverage. The instrument shall be signed by the agent and by the insured to acknowledge receipt of the written memorandum; and

(2) File a duplicate of the memorandum with the company represented by the agent. The company shall retain the duplicate memorandum for a period of three (3) years.

(d) Any agent who shall violate the provisions of this section shall be guilty of a misdemeanor and shall be subject to such reasonable disciplinary action as may be provided by the Arkansas Insurance Code.

23-66-308. Rebates, discounts, abatements, etc.

(a) No property, casualty, or surety insurer or any employee thereof and no broker, agent, or solicitor shall pay, allow, or give, or offer to pay, allow, or give, directly or indirectly, as an inducement to insure or after insurance has been effected, any rebate, discount, abatement, credit, or reduction of the premium named in a policy of insurance, or any special favor or advantage in the dividends or other benefits to accrue thereon, or any valuable consideration or inducement whatever not specified in the policy except to the extent provided for in an applicable filing with the Insurance Commissioner as provided by law.

(b) No insured named in a policy, nor any employee of the insured, shall knowingly receive or accept, directly or indirectly, any such rebate, discount, abatement, credit, or reduction of premium, or any special favor or advantage or valuable consideration or inducement.

(c) Nothing in this section shall be construed as prohibiting the payment of commissions or other compensation to licensed agents, brokers, or solicitors, nor shall it be construed as prohibiting any insurer from allowing or returning to its participating policyholders, members, or subscribers any dividends, savings, or unabsorbed premium deposits.

(d) This section does not include within the definition of rebates or otherwise prohibit the practice of engaging in an arrangement that would not violate section 106 of the Bank Holding Company Act Amendments of 1972, 12 U.S.C. § 1972, as interpreted by the Board of Governors of the Federal Reserve System, or section 1464(q) of the Home Owners Loan Act, 12 U.S.C. § 1461 et seq.

23-66-309. Charge for substitution of policy.

No person engaged in the business of financing the purchase of real or personal property or of lending money on the security of real or personal property and no trustee, director, officer, agent, or other employee of the person shall directly or indirectly require that a borrower pay a consideration of any kind to substitute the insurance policy of one (1) insurer for that of another.

23-66-310. Illegal dealing in premiums - Excess charges for insurance.

(a) No person shall willfully collect any sum as a premium or charge for insurance that is not then provided or is not in due course to be provided, subject to acceptance of the risk by the insurer, by an insurance policy issued by an insurer as authorized by the Arkansas Insurance Code.

(b)(1) No person shall willfully collect as a premium or charge for insurance any sum in excess of the premium or charge applicable to the insurance in accordance with the applicable classifications and rates as filed and approved if necessary by the Insurance Commissioner, or in cases in which classifications, premiums, or rates are not required by the Arkansas Insurance Code to be so filed and approved, the premiums and charges shall not be in excess of those specified in the policy and as fixed by the insurer.

(2) However, the provision in subdivision (b)(1) of this section shall not be deemed to prohibit:

(A) The charging and collection by surplus lines brokers licensed under § 23-65-101 et seq. of the amount of applicable state and federal taxes in addition to the premium and expense of underwriting as required by the insurer on risks written pursuant to the surplus lines law;

(B) The charging and collection by a life insurer of amounts actually to be expended for medical examination of an applicant for life insurance or for reinstatement of a life insurance policy;

(C) A property and casualty agent from charging and collecting interest upon premiums and charges that remain unpaid for a period of thirty (30) days beyond the date that the original premium was due, subject to the supervision of the commissioner. The interest shall not exceed the maximum rate prescribed by the Arkansas Constitution;

(D) The collection of membership dues by a property and casualty agent when membership of the applicant in an organization is a prerequisite of the insurer to the issuance of coverage; or

(E) The charging of a fee by a licensed consultant if the fee is not excessive.

(c) Nothing shall prohibit a duly licensed property or casualty agent or broker from charging a fee to the insured in addition to the premium properly charged for a policy or contract according to the insurer's rate and rule filings with the State Insurance Department provided that:

(1) Each such fee is separately disclosed on the invoice or billing statement mailed or delivered to the insured; and

(2) The aggregate sum of the fees and all producers' commissions or other compensation due and owing for that policy or contract does not exceed twenty percent (20%) of the total gross premium charged the insured by the insurer for that policy or contract.

23-66-311. Business development compensation to life policyholders.

No life insurer shall discriminate between its policyholders by allowing, or agreeing to allow, to any policyholder, whether as an individual or as a member of a class, a portion or percent of any premium collected by the insurer from any policyholder on the pretense of making the policyholder an agent of the insurer or otherwise, unless that policyholder regularly qualifies and is licensed as an agent of the insurer, and is instrumental in actually securing business for the insurer, as evidenced by his or her name appearing on the application or applications of other policyholders, as soliciting agent, and his or her

compensation for the services is limited to a reasonable commission on the business thus secured by the insurer through his or her instrumentality.

23-66-312. Favored agent or insurer - Coercion of debtors.

- (a) No person, including, but not limited to, depository institutions and affiliates of depository institutions, primary and secondary mortgagees, vendors, or lenders may:
- (1) Unreasonably disapprove the insurance policy or binder provided by a borrower for the protection of the property securing the credit or lien;
 - (2)(A) Require, directly or indirectly, that any borrower, mortgagor, purchaser, insurer, broker, or agent pay a separate charge in connection with the handling of any insurance policy or binder required as security for a loan on real estate or pay a separate charge to substitute the insurance policy or binder of one (1) insurer for that of another.
(B) Subdivision (a)(2)(A) of this section does not apply to charges that would be required if the person or depository institution or affiliate of a depository institution is the licensed producer providing the insurance; or
 - (3) Use or disclose information resulting from a requirement that a borrower, mortgagor, or purchaser furnish insurance of any kind when that information is to the advantage of the mortgagee, vendor, or lender or is to the detriment of the borrower, mortgagor, purchaser, insurer, or the agent or broker complying with this requirement.
- (b)(1) Subdivision (a)(2) of this section does not include the interest that may be charged on premium loans or premium advancements in accordance with the security instrument.
- (2)(A) For purposes of subdivision (a)(1) of this section, a rejection shall not be deemed unreasonable if it is based on uniformly applied reasonable standards relating to the extent of coverage required and the financial soundness and the services of an insurer.
(B) The standards shall not discriminate against any particular type of insurer, nor shall the standards call for rejection of a policy because it contains coverage in addition to that required in the credit transaction.
 - (3) Subdivision (a)(3) of this section does not restrict or limit the release of insurance information of a customer by a depository institution to any officer, director, employee, agent, or affiliate of the depository institution for the purpose of soliciting or selling insurance.
 - (4)(A) The Insurance Commissioner may investigate the affairs of any person to whom this subsection applies to determine whether the person has violated this subsection.
(B) If a violation of this subsection is found, the person in violation shall be subject to the same procedures and penalties as are applicable to §§ 23-66-203, 23-66-206, 23-66-207, and 23-66-209 - 23-66-213 and shall be liable for actual or compensatory damages resulting from an unreasonable disapproval of an insurance policy or binder.
 - (5) Once a binder has been issued, the insurer must issue a policy within ninety (90) days.
 - (6) All information given on the binder must be without material change when the policy is issued.
- (c) The provisions of this section do not apply to credit-related insurance, such as credit life or credit accident and health insurance.

23-66-313. Overwriting contracts of life insurer.

- (a) No life insurer shall pay or contract to pay, directly or indirectly, to its president, vice president, secretary, treasurer, actuary, or medical director or other physician charged with the duty of examining risks or applicants for insurance, except regular fees paid for making examinations, nor shall the insurer pay to any officer of the insurer, other than an agent, any commission or other compensation contingent upon the writing or procuring of any policy of insurance in the insurer or procuring an application therefor, by any person whomsoever, or upon the assumption of any life insurance risk or contingent upon the payment of any renewal premium, unless and until the contract providing for the payment shall have first been filed with and approved by the Insurance Commissioner.
- (b) The commissioner shall not approve any contract found by him or her to be unfair or unreasonable or contrary to the best interests of the insurer, or if it provides compensation other than reasonable compensation for substantial service actually rendered or to be rendered to the insurer.
- (c) If any insurer violates this section, the commissioner shall revoke its certificate of authority.

23-66-314. Common ownership, management, and directors of insurance companies.

- (a) Any insurer may retain, invest in, or acquire the whole or any part of the capital stock of any other insurers, or have a common management with any other insurers, unless the retention, investment, acquisition, or common management is inconsistent with any other provision of the Arkansas Insurance Code, or unless by reason thereof the business of the insurers with the public is conducted in a manner which substantially lessens competition generally in the insurance business or tends to create a monopoly therein.
- (b) Any person otherwise qualified may be a director of two (2) or more insurers which are competitors unless the effect thereof is to lessen substantially competition between insurers generally or tends materially to create a monopoly.

23-66-315. Confidential information.

- (a)(1) When a borrower is required to maintain insurance and to furnish evidence of the insurance to a depository institution, an affiliate of a depository institution, creditor, mortgagee, assignee, or lender as a condition for obtaining or keeping the loan, the lender, mortgagee, assignee, or creditor is prohibited from disclosing to other persons or parties, directly or indirectly, information with respect to the expiration dates of the insurance or other insurance policy information so as to enable any person or party to solicit the insurance or any renewal thereof, without first obtaining the written consent of the policyholder for such a disclosure to be made.
- (2) Nor shall any other person or party request the disclosure of the information, so as to facilitate solicitations of the insurance or any renewal thereof, without first obtaining the written consent of the policyholder.
- (3) Nor shall any lender, mortgagee, assignee, or creditor use any of the information contained in a policy of insurance for the purpose of soliciting insurance business with respect to the insured real property from the borrower.

(b) These prohibitions do not apply to disclosure of insurance information of a customer to any officer, director, employee, agent, or affiliate of the depository institution for the purpose of soliciting or selling insurance or when the depository institution, an affiliate of a depository institution, lender, mortgagee, assignee, or creditor has been advised in writing by the insurer or its agent that the insurance on the property will be cancelled or will not be renewed.

(c) Willful violation of this section by any depository institution, an affiliate of a depository institution, lender, mortgagee, assignee, or creditor or by any other person or party who may request the disclosure of the information from the lender, mortgagee, assignee, or creditor shall be punishable as a Class C misdemeanor.

23-66-316. Advertising by health and accident insurers and prepaid health plans.

(a) It shall be unlawful for any insurance company or association transacting any health and accident or hospital or surgical insurance or prepaid hospital and surgical or health care plan in this state, in violation of a prior order or regulation of the Insurance Commissioner directed to the company or association, to make, issue, circulate, or place before the public or to cause the making, issuing, circulation, or placing before the public, in a newspaper, magazine, or other publication, or in the form of a notice, brochure, circular, pamphlet, letter, or poster, or by way of any radio or television station, or in any other way or manner, any advertisement, announcement, or statement with respect to the terms, benefits, premiums, or advantages of the policy or plan, unless and until the advertisement, announcement, or statement has been filed with and approved by the commissioner, pursuant to the prior order or regulation, as not being untrue, deceptive, or misleading in any respect.

(b) Any company or association violating the provisions of this section shall be guilty of a misdemeanor and upon a first conviction shall be fined not less than one hundred dollars (\$100) nor more than five hundred dollars (\$500) and for a second or subsequent conviction shall be fined not less than five hundred dollars (\$500) nor more than five thousand dollars (\$5,000). Each violation shall constitute a separate offense.

23-66-317. Effect of a consumer report on issuance or renewal of coverage. [Repealed effective January 1, 2004.]

(a) As used in this section, the term "consumer report" means any written, oral, or other communication of any information by a consumer reporting agency bearing on a consumer's credit worthiness, credit capacity, character, general reputation, personal characteristics, or mode of living which is used or expected to be used or collected in whole or in part for the purpose of serving as a factor in establishing the consumer's eligibility for insurance and other purposes authorized by the federal Fair Credit Reporting Act. A consumer report shall not include motor vehicle records or claims records.

(b) No insurer shall refuse to issue or renew coverage or limit the amount of coverage on a risk in this state based solely upon the insurer's knowledge of the insured's or applicant's consumer report, unless:

- (1) The consumer report of the insured or applicant can be shown to identify characteristics which substantially increase the risk of loss at or after policy issuance or renewal;
- (2) The insurer or its agent sends a notice of cancellation, refusal to renew, or declination to the insured or applicant which contains a statement which advises that the cancellation, nonrenewal, or declination is based on information contained in a consumer report relating to an applicant or insured or other resident of the household; and
- (3) The insurer or its agent sends to the applicant or insured the name and address of the institutional source from which the insurer obtained the consumer report and advises the applicant or insured that if more detail on the credit information which formed the basis of the decision is desired, a free copy of the consumer report may be obtained by making a written request or by appearing in person at the credit reporting agency or such other party as the insurer shall identify in the notice, not more than ten (10) days after the date on which the notice of cancellation, nonrenewal, or declination was mailed to the insured or applicant.
- (c) If the insurer is relying solely upon a credit scoring system or model in reaching its underwriting decision, the insurer must:
 - (1) File the credit scoring system with the Insurance Commissioner; and
 - (2) Provide the applicant or insured with a clear, concise explanation of the factors taken into consideration in reaching its decision.
- (d) If used for rating, the guidelines on the use of consumer reports or consumer report scoring system or model must be filed with the commissioner.
- (e) If an insurer chooses to utilize a consumer report or credit scoring system or model in underwriting a class or subclass of applicants, the insurer must apply the same criteria for all applicants in the class or subclass of business. However, nothing in this section is intended to prevent an insurer from considering each risk on an individual basis nor is it intended to interfere with an insurer's right to rescind a contract ab initio based upon a material misrepresentation in the application.
- (f) The provisions of this section shall be subject to provisions of the federal Truth in Lending Act and the federal Fair Credit Reporting Act.
- (g) No insurer may condition the issuance of an insurance policy in this state upon the fact that an applicant or insured does not possess a credit card.
- (h) Any proprietary consumer report scoring system or model filed with the commissioner under this section shall remain confidential.
- (i) This section shall only apply to personal lines of property and casualty insurance.

23-66-318. Claims or loss histories - Provision for copies to named insureds.

- (a)(1) A vendor of loss history information shall make all disclosures and furnish the reports without charge to the insured if within thirty (30) days after receipt by the insured of a notification of declination, cancellation, nonrenewal, or reduction in coverage the insured so requests.
- (2) Otherwise, the vendor of loss history information may impose a reasonable charge on the insured for making disclosure.

- (b) Property and casualty insurers are not required to send such reports to named insureds when transmitting the data or reports to licensed rate service or advisory organizations for statistical or statutory data compilation purposes.
- (c)(1) The provisions of this section are intended to and shall apply only to personal lines insurance issued by property and casualty insurers authorized to transact insurance business in this state, and are not intended to apply to commercial lines property and casualty insurance.
- (2) The provisions of this section are not intended to conflict with any state insurance laws which require insurers to furnish loss histories to insureds or named insureds upon request.

23-66-319. Cancellation of insurance policies by third parties.

- (a) Anyone holding the right to request cancellation of the named insured's insurance policy, other than the insurer, shall send to the insured and to the insured's agent or broker of record at least ten (10) days' written notice of the intention to cancel the policy. The right to be mailed this notice is personal to the named insured and cannot be waived, nor may it be assigned by the insured to the person or entity that holds the right to request the cancellation.
- (b) After expiration of the ten-day period in which to cure the default, a notice of cancellation of the policy may be sent to the insurer, with a copy to the named insured.
- (c) Any notices failing to comply with this section shall be ineffective to cancel the policy.
- (d) This section shall not apply to annuities or disability or life insurance.

23-66-320. Genetic Nondiscrimination in Insurance Act.

- (a) This section shall be known and may be cited as the "Genetic Nondiscrimination in Insurance Act".
- (b) For the purposes of this section:
- (1) "Disability insurance" means insurance of human beings against bodily injury, disablement, or death by accident or accidental means, or the expense thereof, or against disablement or expense resulting from sickness, and every insurance appertaining thereto, but shall not include disability income or long-term care insurance;
- (2) "DNA" means deoxyribonucleic acid;
- (3)(A) "Genetic information" means information derived from the results of a genetic test.
- (B) Genetic information shall not include:
- (i) Family history;
- (ii) The results of a routine physical examination or test;
- (iii) The results of a routine chemical, blood, or urine analysis;
- (iv) The results of a test to determine drug use;
- (v) The results of a test for the presence of the human immunodeficiency virus; or
- (vi) The results of any other test commonly accepted in clinical practice at the time it is ordered by the insurer;

(4)(A) "Genetic test" means a laboratory test of the DNA, RNA, chromosomes, or enzyme activity for genetic disease of an individual for the purpose of identifying the presence or absence of inherited alterations in the DNA, RNA, chromosomes, or enzyme activity for genetic disease that cause a predisposition for a clinically recognized disease or disorder.

(B) "Genetic test" shall not include:

- (i) A routine physical examination or a routine test performed as a part of a physical examination;
- (ii) A chemical, blood, or urine analysis;
- (iii) A test to determine drug use;
- (iv) A test for the presence of the human immunodeficiency virus; or
- (v) Any other test commonly accepted in clinical practice at the time it is ordered by the insurer;

(5)(A) "Insurer" means any individual, corporation, association, partnership, insurance support organization, fraternal benefit society, insurance agent, third-party administration, self-insurer, or any other legal entity engaged in the business of insurance which is licensed to do business in or incorporated or domesticated or domiciled in or under the statutes of this state, or actually engaged in business in this state, regardless of where the contract of insurance is written or the plan is administered or where the corporation is incorporated, that issues disability policies or plans or that administers any other type of disability insurance policy containing medical provisions, including, but not limited to, any nonprofit hospital service and indemnity and medical service and indemnity corporation, health maintenance organizations, preferred provider organizations, prepaid health plans, and the State and Public School Life and Health Insurance Plan.

(B) "Insurer" shall not include insurers issuing life, disability income, or long-term care insurance;

(6)(A) "Policy" or "policy form" means any:

- (i) Policy, contract, plan, or agreement of disability insurance, or subscriber certificates of medical care corporations, health care corporations, hospital service associations, or health care maintenance organizations, delivered or issued for delivery in this state by any insurer;
- (ii) Certificate, contract, or policy issued by a fraternal benefit society;
- (iii) Certificate issued pursuant to a group insurance policy delivered or issued for delivery in this state; and
- (iv) Evidence of coverage issued by a health maintenance organization.

(B) "Policy" or "policy form" shall not include life, disability income, and long-term care insurance policies; and

(7) "RNA" means ribonucleic acid.

(c) No insurer, for the purpose of determining eligibility of any individual for any insurance coverage, establishing premiums, limiting coverage, renewing coverage, terminating coverage, or any other underwriting decision in connection with the offer, sale, or renewal or continuation of a policy, except to the extent and in the same fashion as an insurer limits coverage or increases premiums for loss caused or contributed to by other medical conditions presenting an increased degree of risk, shall:

- (1) Require or request, directly or indirectly, any individual or a member of the individual's family to obtain a genetic test; and
 - (2) Condition the provision of the policy upon a requirement that an individual take a genetic test.
- (d) Nothing in this section shall limit an insurer's right to decline an application or enrollment request for a policy, charge a higher rate or premium for such a policy, or place a limitation on coverage under such a policy, on the basis of manifestations of any condition, disease, or disorder.
- (e)(1) Any violation of subsections (c) and (d) of this section by an insurer shall be deemed an unfair practice pursuant to § 23-66-206.
- (2) In addition, any individual who is damaged by an insurer's violation of this section may recover in a court of competent jurisdiction equitable relief, which may include a retroactive order, directing the insurer to provide insurance coverage to the damaged individual under the same terms and conditions as would have applied had the violation not occurred.
- (f) Notwithstanding any language in this section to the contrary, this section shall not apply to an insurer or to an individual or third-party dealing with an insurer in the ordinary course of underwriting, conducting, or administering the business of life, disability income, or long-term care insurance.

23-66-321. Method of payment of claims.

All claims paid by an insurer authorized to do business in this state to any person having a claim under any insurance contract for any type of insurance authorized by the laws of this state issued by an insurer shall be paid by check or draft of the insurer to the order of, or by electronic funds transfer to an account of, the claimant to whom payment of the claim is due pursuant to the policy provisions.

Subchapter 4. Home Service Act.

23-66-401. Title.

This subchapter may be cited as the "Home Service Act".

23-66-402. Definitions.

As used in this subchapter:

- (1) A "blind" is the collection of a premium from a policyowner or premium payor who is intentionally not made aware of the correct paid-to status of the policy for which the premium is to be applied because a premium intentionally was not properly recorded pursuant to § 23-66-405(1);
- (2) "Commissioner" means the Insurance Commissioner of this state;
- (3) "Customarily collected" means that in his or her ordinary course of business, the agent collects premiums for the policy on site at a payor's home or business;

(4)(A) "Customarily marketed, issued, or delivered" means that in his or her ordinary course of business, the agent markets, issues, or delivers the policy on site at a payor's home or business.

(B) "Customarily marketed, issued, or delivered" does not include any solicitation or sale made at the home or workplace of a person, if it will not thereafter be the ordinary course of business of the agent to either collect premiums from the person on site at his or her home or workplace, or regularly service the premium payor or policyowner on site at his or her home or workplace; and

(5) "Home service system of distribution" is a manner of selling insurance policies which are customarily marketed, issued, or delivered by an agent in person at a payor's home or business, or is a manner of collecting premiums in which premiums are customarily collected in person at a payor's home or business by an agent. This shall not include the sale of commercial policies, crop or hail policies, or term policies covering crops whether harvested or unharvested, or policies covering grain, hay, chemicals, or fertilizer.

23-66-403. Rules and regulations.

The Insurance Commissioner shall have such authority as he or she deems reasonably necessary to regulate the home service system of distribution, and, to that end, to promulgate, adopt, and enforce reasonable rules and regulations necessary and proper to regulate the home service system of distribution.

23-66-404. Required practices.

Each insurer engaged in the home service system of distribution of policies in this state shall:

- (1)(A) Establish written procedures to audit agencies engaged in the home service system of distribution of policies in this state;
 - (B) File the audit procedures in effect each year with the annual statement or provide a certification with each annual statement that the procedures have been adopted;
 - (C) Conduct audits periodically, or in the manner as described by rules and regulation, at the field level or premium payor level which reasonably ensure that the premium payor's premium recording item or records accurately reflect the premium due date and premium paid-to status of the policy or policies purchased;
 - (D) Provide a receipt or record to the premium payor reflecting the amount of the premium paid, the date of payment, and the policy number, or other identifying characteristics, toward which the premium is paid if the premium receipt book or other premium recording record is unavailable for marking the premium payments of the payor; and
 - (E) Provide to a policy owner or premium payor upon request the current paid-to status of any and all policies owned within forty-five (45) days, and, in the event the records of the policy owner or premium payor differ, adjust the company records to credit the policy any previously uncredited payments for which a receipt or other reasonable evidence of payment is submitted by the policy owner; and
- (2) With the delivery of the policy, provide notice in bold print with at least ten-point font or size which states:

- (A) That a premium savings may be realized by a different or less frequent method of premium payment;
- (B) That premiums are still due and payable by the person responsible for premium payments even when an agent does not collect the premiums; and
- (C) The mailing address for payment of premiums to the company.

23-66-405. Premiums.

For every premium collected on a policy of property, casualty, life, or accident and health insurance in this state, the agent collecting or receiving such a premium shall:

- (1) Furnish the payor with written evidence of payment at the time the premium is collected, which shall include the amount paid, the date paid, the date-paid-to status of the policy, the policy number or the identifying characteristics for which the payment will be credited, the signature or signed initials of the agent, and the office address and phone number of the insurer; and
- (2) Remit to the insurer's home office or applicable district office the premium collected within ten (10) days of receipt from the premium payor or policy owner.

23-66-406. Deceptive practices.

The following activities, if committed intentionally, shall be deceptive acts under § 23-66-201 et seq. for companies or agents engaged in the home service system of distribution:

- (1) The commission of a blind as defined by § 23-66-402;
- (2) The collection of a premium which is not due from a premium payor or policy owner, and, without the knowledge of the premium payor or policy owner, the crediting of that premium to future coverage for a policy owner;
- (3) The collection of a premium which is not due from a premium payor or policy owner, and, without the knowledge of the premium payor or policy owner, the crediting of that premium for a different policy owner;
- (4) The use or transfer of any excess or unused funds remaining in the account of the premium payor or policy owner to procure or revive an insurance policy for a policy owner without the knowledge or authorization of the payor; and
- (5) The collection of a premium by an agent who retains the premium for his or her own personal use.

23-66-407. Private cause of action.

No violation of this subchapter shall be deemed to give rise to a private cause of action.

23-66-408. Violations.

- (a) The Insurance Commissioner shall conduct all hearings held pursuant to allegations of violations of this subchapter pursuant to §§ 23-61-303 - 23-61-307.

(b) The commissioner may suspend for up to twelve (12) months, or may revoke or refuse to continue, any license issued by him or her which is the subject of an administrative hearing held pursuant to a violation of this subchapter.

(c) The commissioner may additionally impose upon the licensee an administrative penalty in the amount of not more than one thousand dollars (\$1,000) for each and every act or violation, but not to exceed an aggregate penalty of ten thousand dollars (\$10,000), unless the person knew or reasonably should have known the person was in violation of this subchapter, in which case, the penalty shall be not more than five thousand dollars (\$5,000) for each and every act or violation, but in an amount not to exceed an aggregate penalty of fifty thousand dollars (\$50,000) in any six-month period.

Subchapter 5.

Fraudulent Insurance Acts Prevention.

23-66-501. Definitions.

As used in this subchapter, unless the context otherwise requires:

- (1) "Actual malice" means knowledge that information is false, or reckless disregard of whether it is false;
- (2) "Business of insurance" means the writing of insurance or the reinsuring of risks by an insurer, including acts necessary or incidental to writing insurance or reinsuring risks and the activities of persons who act as, or are officers, directors, agents, or employees of insurers, or who are other persons authorized to act on their behalf;
- (3) "Commissioner" means the Insurance Commissioner of this state;
- (4) "Fraudulent insurance act" means an act or omission committed by a person who, knowingly and with intent to defraud, commits, or conceals any material information concerning, one or more of the following:
 - (A) Presenting, causing to be presented, or preparing with knowledge or belief that it will be presented to an insurer, a reinsurer, broker or its agent, or by a broker or agent, false information as part of, in support of, or concerning a fact material to one or more of the following:
 - (i) An application for the issuance or renewal of an insurance policy or reinsurance contract;
 - (ii) The rating of an insurance policy or reinsurance contract;
 - (iii) A claim for payment or benefit pursuant to an insurance policy or reinsurance contract;
 - (iv) Premiums paid on an insurance policy or reinsurance contract;
 - (v) Payments made in accordance with the terms of an insurance policy or reinsurance contract;
 - (vi) A document filed with the commissioner or the chief insurance regulatory official of another jurisdiction;
 - (vii) The financial condition of an insurer or reinsurer;
 - (viii) The formation, acquisition, merger, reconsolidation, dissolution, or withdrawal from one or more lines of insurance or reinsurance in all or part of this state by an insurer or reinsurer;

- (ix) The issuance of written evidence of insurance; or
- (x) The reinstatement of an insurance policy;
- (B) Solicitation or acceptance of new or renewal insurance risks on behalf of an insurer, reinsurer, or other person engaged in the business of insurance by a person who knows or should know that the insurer or other person responsible for the risk is insolvent at the time of the transaction;
- (C) Removal, concealment, alteration, or destruction of the assets or records of an insurer, reinsurer, or other person engaged in the business of insurance;
- (D) Willful embezzlement, abstracting, purloining or conversion of moneys, funds, premiums, credits, or other property of an insurer, reinsurer, or person engaged in the business of insurance;
- (E) Transaction of the business of insurance in violation of laws requiring a license, certificate of authority, or other legal authority for the transaction of the business of insurance; or
- (F) Attempt to commit, aiding or abetting in the commission of, or conspiracy to commit the acts or omissions specified in this subsection;
- (5)(A) "Insurance" means a contract or arrangement in which one undertakes to:
 - (i) Pay or indemnify another as to loss from certain contingencies called "risks", including through reinsurance;
 - (ii) Pay or grant a specified amount or determinable benefit to another in connection with ascertainable risk contingencies;
 - (iii) Pay an annuity to another; or
 - (iv) Act as surety.
- (B) "Insurance" shall, for the purposes of this subchapter, be deemed to include any definition used in the Arkansas Insurance Code;
- (6) "Insurer" means a person entering into arrangements or contracts of insurance or reinsurance and who agrees to perform any of the acts set forth in subdivision (5)(A) of this section. A person is an insurer regardless of whether the person is acting in violation of laws requiring a certificate of authority or regardless of whether the person denies being an insurer;
- (7) "NAIC" means the National Association of Insurance Commissioners;
- (8)(A) "Person" means an individual, corporation, partnership, association, joint stock company, trust, unincorporated organization, or any similar entity or any combination of the foregoing;
- (B) "Person" shall, for the purposes of this subchapter, be deemed to include any definition used in the Arkansas Insurance Code;
- (9) "Policy" means an individual or group policy, group certificate, contract, or arrangement of insurance or reinsurance affecting the rights of a resident of this state or bearing a reasonable relation to this state, regardless of whether delivered or issued for delivery in this state; and
- (10) "Reinsurance" means a contract, binder of coverage, including placement slip, or arrangement under which an insurer procures insurance for itself in another insurer as to all or part of an insurance risk of the originating insurer.

23-66-502. Fraudulent insurance acts, interferences, and participation of convicted felons prohibited.

- (a) A person shall not commit a fraudulent insurance act.
- (b) A person shall not knowingly or intentionally interfere with the enforcement of the provisions of this subchapter or investigations of suspected or actual violations of this subchapter.
- (c)(1) A person convicted of a felony involving dishonesty or breach of trust shall not participate in the business of insurance, unless the person was pardoned, the conviction was expunged, or the person has obtained the written consent of the Insurance Commissioner pursuant to subsection (d) of this section.
- (2) A person in the business of insurance shall not knowingly or intentionally permit a person convicted of a felony involving dishonesty or breach of trust to participate in the business of insurance, unless the person was pardoned, the conviction was expunged, or the person has obtained the written consent of the commissioner pursuant to subsection (d) of this section.
- (d)(1) A person described in subdivision (c)(1) of this section may participate in the business of insurance if written consent is obtained from the commissioner who, in the commissioner's sole discretion, may grant the written consent upon a finding that to do so would not endanger the public health, safety, and welfare.
- (2) Notwithstanding any other provision in this subchapter, a person convicted in this state of a felony involving a fraudulent insurance act, dishonesty, or breach of trust after having obtained the written consent of the commissioner under this subsection shall have the fine and term of imprisonment for such a class of felony under the Arkansas Criminal Code enhanced to that of the next highest classification and shall be permanently disqualified from participating in the business of insurance in this state. If after obtaining the written consent of the commissioner under this subsection a person is convicted in a foreign jurisdiction of a felony involving a fraudulent insurance act, dishonesty, or breach of trust, the person shall be permanently disqualified from participating in the business of insurance in this state.

23-66-503. Fraud warning required.

- (a) Claim forms, proofs of loss, or any similar documents, however designated, seeking payment or benefit pursuant to an insurance policy, and applications for insurance, regardless of the form of transmission, shall contain the following statement or a substantially similar statement:

"Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."
- (b) The lack of a statement as required in subsection (a) of this section does not constitute a defense in any prosecution for a fraudulent insurance act.
- (c) Policies issued by unauthorized insurers shall contain a statement disclosing the status of the insurer to do business in the state where the policy is delivered or issued for delivery or the state where coverage is in force. The requirement of this subsection may be satisfied by a disclosure specifically required by § 23-65-307.
- (d) The requirements of this section shall not apply to reinsurance proofs of loss or applications.

23-66-504. Investigative authority of the commissioner.

The Insurance Commissioner may investigate suspected fraudulent insurance acts and persons engaged in the business of insurance.

23-66-505. Mandatory reporting of fraudulent insurance acts.

- (a) A person engaged in the business of insurance having knowledge or a reasonable belief that a fraudulent insurance act is being, will be, or has been committed shall provide to the Insurance Commissioner the information required by, and in a manner prescribed by, the commissioner.
- (b) Any person engaged in the business of insurance who knowingly fails to report as required by subsection (a) of this section shall be guilty of a misdemeanor and upon conviction shall be punished by a fine not to exceed one thousand dollars (\$1,000) or by imprisonment for a period not to exceed one (1) year, or by both fine and imprisonment.
- (c) Any other person having knowledge or a reasonable belief that a fraudulent insurance act is being, will be, or has been committed may provide to the commissioner the information required by, and in a manner prescribed by, the commissioner.

23-66-506. Immunity from liability.

- (a) There shall be no civil liability for libel, slander, or any other cause of action imposed on, and no cause of action shall arise from a person's furnishing information concerning suspected, anticipated, or completed fraudulent insurance acts, if the information is provided to or received from:
 - (1) The Insurance Commissioner or the commissioner's employees, agents, or representatives;
 - (2) Federal, state, or local law enforcement or regulatory officials or their employees, agents, or representatives;
 - (3) A person employed by or authorized by an insurer whose activities include the investigation or reporting of suspected fraudulent insurance acts when furnishing, disclosing, or requesting information on such suspected fraudulent insurance acts to or from a person employed by or authorized by other insurers or insurer organizations acting in the same capacity; or
 - (4) The National Association of Insurance Commissioners or its employees, agents, or representatives.
- (b) Subsection (a) of this section shall not apply to statements made with actual malice. In an action brought against a person for filing a report or furnishing other information concerning a fraudulent insurance act, the party bringing the action shall plead specifically any allegation that subsection (a) of this section does not apply because the person filing the report or furnishing the information did so with actual malice.
- (c) This section does not abrogate or modify common law or statutory privileges or immunities enjoyed by a person described in subsection (a) of this section.

23-66-507. Confidentiality.

(a) Notwithstanding any other provision of law, the documents and evidence provided pursuant to §§ 23-66-505 and 23-66-508 or obtained by the Insurance Commissioner in an investigation of suspected or actual fraudulent insurance acts shall be privileged and confidential and shall not be a public record and shall not be subject to discovery or subpoena in a civil or criminal action until the matter under investigation is closed by the Insurance Fraud Investigation Division with the consent of the commissioner.

(b) Subsection (a) of this section does not prohibit release by the commissioner of documents and evidence obtained by the division in an investigation of suspected or actual fraudulent insurance acts:

(1) In administrative or judicial proceedings to enforce laws administered by the commissioner;

(2) To federal, state, or local law enforcement or regulatory agencies, to an organization established for the purpose of detecting and preventing fraudulent insurance acts, or to the National Association of Insurance Commissioners; or

(3) At the discretion of the commissioner, to a person in the business of insurance that is aggrieved by a fraudulent insurance act.

(c) Release of documents and evidence under subsection (b) of this section does not abrogate or modify the privilege granted in subsection (a) of this section.

23-66-508. Creation and purpose of the Insurance Fraud Investigation Division.

(a)(1) The Insurance Fraud Investigation Division is established within the State Insurance Department.

(2) The Insurance Commissioner shall appoint the full-time supervisory and investigative personnel of the division, who shall be qualified by training and experience to perform the duties of their positions.

(3)(A) The commissioner shall designate the personnel assigned to the division, who, upon meeting the qualifications established by the Arkansas Commission on Law Enforcement Standards and Training, shall have the powers of specialized law enforcement officers of the State of Arkansas for the purpose of conducting investigations under § 23-66-504 and any criminal violations related to those investigations.

(B) Personnel hired as specialized law enforcement officers shall have a minimum of three (3) years of certified law enforcement experience or its equivalent in national or military law enforcement experience as approved by the Arkansas Commission on Law Enforcement Standards and Training.

(4) The commissioner shall also appoint clerical and other staff necessary for the division to carry out its duties and responsibilities under this subchapter.

(b) It shall be the duty of the division to:

(1) Initiate independent inquiries and conduct independent investigations when the division has cause to believe that a fraudulent insurance act may be, is being, or has been committed;

(2) Review reports or complaints of alleged fraudulent insurance activities from federal, state, and local law enforcement and regulatory agencies, persons engaged in the business

of insurance, and the public to determine whether the reports require further investigation and to conduct these investigations; and

(3) Conduct independent examinations of alleged fraudulent insurance acts and undertake independent studies to determine the extent of fraudulent insurance acts.

(c) The division shall have the authority to:

(1)(A) Issue subpoenas to examine any individual under oath and to compel the production of records, books, papers, contracts, and other documents.

(B) Subpoenas shall be served in the same manner as if issued by a circuit court.

(C) If any individual fails to obey a subpoena issued and served pursuant to this subsection, upon application of the division, the Pulaski County Circuit Court or the circuit court of the county where the subpoena was served may issue an order requiring the individual to comply with the subpoena.

(D) Any failure to obey the order of the court may be punished by the court as contempt thereof;

(2) Administer oaths and affirmations;

(3) Share records and evidence with federal, state, or local law enforcement or regulatory agencies;

(4)(A) Make criminal referrals to prosecuting authorities.

(B) The prosecuting attorney of the judicial district where a criminal referral has been made shall, for the purpose of assisting in the prosecution, have the authority to appoint as special deputy prosecuting attorneys licensed attorneys in the employment of the division.

(C) The prosecuting attorney shall have the right and discretion to proceed against any person or organization on criminal referrals made hereunder, both organizational and individual liability being intended; and

(5)(A) Conduct investigations outside of this state.

(B) If the information the division seeks to obtain is located outside this state, the person from whom the information is sought may make the information available to the division to examine at the place where the information is located.

(C) The division may designate representatives, including officials of the state in which the matter is located, to inspect the information on behalf of the division, and the division may respond to similar requests from officials of other states.

23-66-509. Other law enforcement of regulatory authority.

This subchapter shall not:

(1) Preempt the authority or relieve the duty of other law enforcement or regulatory agencies to investigate, examine, and prosecute suspected violations of law;

(2) Prevent or prohibit a person from disclosing voluntarily information concerning insurance fraud to a law enforcement or regulatory agency other than the Insurance Fraud Investigation Division; or

(3) Limit the powers granted elsewhere by the laws of this state to the Insurance Commissioner or the division to investigate and examine possible violations of law and to take appropriate action against wrongdoers.

23-66-510. Insurer antifraud initiative.

(a) Insurers shall have antifraud initiatives reasonably calculated to detect, prosecute, and prevent fraudulent insurance acts. Antifraud initiatives may include, but are not limited to:

(1) Fraud investigators, who may be insurer employees or independent contractors; or
(2) An antifraud plan submitted to the Insurance Commissioner. Antifraud plans submitted to the commissioner shall be privileged and confidential and shall not be a public record and shall not be subject to discovery or subpoena in a civil or criminal action.

(b) Upon the written request of an insurer, the commissioner may grant an exemption from the requirements of this section if the commissioner determines that such an exemption would not be detrimental to the interests of the public.

23-66-511. Regulations.

The Insurance Commissioner may promulgate reasonable rules and regulations deemed necessary by the commissioner for the administration of this subchapter.

23-66-512. Penalties.

A person who violates this subchapter is subject to the following:

(1)(A) Suspension or revocation of license, civil penalties of up to ten thousand dollars (\$10,000) per violation, or both.

(B) Suspension or revocation of license and imposition of civil penalties shall be pursuant to an order of the Insurance Commissioner issued under § 23-61-301 et seq.

(C) The commissioner's order may require a person found to be in violation of this subchapter to make restitution to persons aggrieved by violations of this subchapter; and

(2)(A) A person convicted of a violation of § 23-66-502 by a court of competent jurisdiction shall be guilty of a Class D felony.

(B) A person convicted of a violation of § 23-66-502 shall be ordered to pay restitution to persons aggrieved by the violation of this subchapter.

(C) Restitution shall be ordered in addition to a fine or imprisonment; and

(3) A person convicted of a felony violation of this subchapter pursuant to subdivision (2) of this section shall be disqualified from engaging in the business of insurance.

23-66-513. Initial appointment investigation.

(a)(1)(A) Prior to the approval of any application or request for appointment by an insurer or company to be added to the license obtained by an individual resident agent or producer who has had no previous appointments on his or her Arkansas license prior to this request, the insurer shall conduct or secure at its expense an investigation as to the applicant's identity, residence, experience, or instruction as to the kinds of insurance to be transacted, and as to the agent's or producer's character, financial condition, and financial history.

(B) The Insurance Commissioner may accept a background check performed by the National Association of Securities Dealers for any required broker or producer background check required by this section.

(2) At a minimum, the investigation shall include the following information disclosed by the investigation:

(A) Whether the applicant has been convicted of a felony and, if so, the date and nature of the conviction, the name and location of the court, and the penalty imposed or other disposition of the case, for review in compliance with the provisions of § 23-66-502(c) and other applicable state or federal laws;

(B) Whether, at the time of the application, the agent or applicant is a named party in any lawsuit and, if so, the style of the lawsuit, a brief description of the litigation, and the name and location of the court;

(C) Whether a judgment for monetary damages has been entered against the applicant within the last five (5) years and, if so, the date of the judgment, the amount of the judgment, whether the judgment has been paid or otherwise satisfied, the name and location of the court, and the style of the case; and

(D) Such other information as the commissioner shall require.

(3) The forms and the requirements of this subsection shall not apply to:

(A) Any limited or restricted license as defined in § 23-64-502(7) or (9), any limited or restricted license that the commissioner may exempt, or any temporary license the commissioner may issue;

(B) Corporations, partnerships, limited liability companies, and partnerships licensed as insurance agencies under this chapter; and

(C) Any individual requesting a renewal license or requesting his or her second or subsequent insurer appointments added after the first-time license or appointment.

(b) The requirements for broker or producer background checks of subdivisions (a)(1) and (2) of this section shall apply to each first-time original license applicant for a resident broker's or producer's license in this state. However, those requirements shall not be required for any renewal broker's or producer's license, and all filings shall exclude appointment forms for first or renewal licenses for brokers or producers.

Subchapter 6.

Insurance Sales Consumer Protection Act.

23-66-601. Short title.

This subchapter may be cited as the "Insurance Sales Consumer Protection Act".

23-66-602. Purpose.

The purpose of this subchapter is to regulate the business of insurance and protect the interests of insurance consumers.

23-66-603. Definitions.

For the purpose of this subchapter:

- (1) "Affiliate" means any company that controls, is controlled by, or is under common control with another company;
- (2) "Customer" means a person who obtains, applies for, or is solicited to obtain insurance products primarily for personal, family, and household purposes;
- (3) "Depository institution" means a bank or savings association and does not include an insurance company;
- (4) "Insurance" means all policies or products defined or regulated as insurance pursuant to § 23-60-101 et seq. except:
 - (A) Credit life, credit accident and health, credit property, credit casualty, credit involuntary unemployment, mortgagor's decreasing term life, and mortgagor's accident and health and sickness insurance;
 - (B) Insurance placed by a financial institution in connection with collateral pledged as security for a loan when the debtor breaches the contractual obligation to provide that insurance; and
 - (C) Private mortgage insurance;
- (5) "Insurance information" means information concerning the premiums, terms, and conditions of insurance coverage, including expiration dates and rates, and insurance claims of a customer contained in the records of a depository institution or an affiliate of a depository institution; and
- (6) "Person" means any natural or artificial entity, including, but not limited to, individuals, partnerships, associations, trusts, or corporations.

23-66-604. Exemption.

The provisions of § 23-66-606 shall not apply to or affect in any way a broker-dealer licensed by the State of Arkansas when such a broker-dealer is conducting insurance sales activities on premises other than depository institution or an affiliate of a depository institution premises.

23-66-605. Insurance in connection with a loan.

- (a) The following shall apply when insurance is required as a condition of obtaining a loan or extension of credit:
 - (1)(A) No person, depository institution, or affiliate of a depository institution may require as a condition precedent to the lending of money or extension of credit, or any renewal thereof, that the person to whom the money or credit is extended or whose obligation a creditor is to acquire or finance, negotiate any policy or renewal thereof through a particular insurer or group of insurers or agent or broker or group of agents or brokers.
 - (B) Further, no person, depository institution, or affiliate of a depository institution may reject an insurance policy solely because the policy has been issued or underwritten by a person who is not associated with the depository institution or affiliate when insurance is required in connection with a loan or extension of credit;
- (2) The loan or extension of credit and related insurance transactions shall be completed through separate documentation; and

(3) A loan for premiums on required insurance, other than a loan for credit insurance premiums or flood insurance premiums, shall not be included in the primary credit without the written consent of the customer.

(b)(1)(A) As a condition for extending credit or offering any product or service that is equivalent to an extension of credit, no person, depository institution, or affiliate of a depository institution may require that a customer obtain insurance from a depository institution, an affiliate of a depository institution, or a particular insurer or producer.

(B) Nothing in this subchapter or § 23-60-101 et seq., shall be construed to prohibit depository institution or affiliate of a depository institution personnel from informing customers that insurance is required in order to obtain a loan or extension of credit or that loan or extension of credit approval is contingent upon the customers' obtaining acceptable insurance.

(2) Depository institution or affiliate of a depository institution personnel may also inform customers that insurance is available from the depository institution, an affiliate of a depository institution, or particular unaffiliated third parties, and indicate how to obtain additional information.

23-66-606. Depository institution or affiliates of a depository institution sales practices.

The following requirements shall apply to insurance sales activities conducted by depository institutions, their employees, affiliates of a depository institution, and unaffiliated third parties conducting the insurance sales activities on behalf of a depository institution or affiliate of a depository institution that involves the use of a depository institution or affiliate of a depository institution brand name or on depository institution or affiliate of a depository institution's premises:

(1) Disclosures.

(A) The following disclosures are required with respect to the solicitation of insurance products or policies and shall be made in writing, where practicable, in a clear and conspicuous manner prior to the sale:

- (i) That the insurance product or policy is not insured by the Federal Deposit Insurance Corporation or insured by any other federal government agency;
- (ii) That the insurance product or policy is not a deposit or obligation of or guaranteed by the lending depository institution or affiliate of a depository institution; and
- (iii) Where appropriate, that certain insurance products involve investment risks, including the possible loss of principal or loss of value.

(B)(i) When an application by a customer for a loan or other extension of credit from a depository institution or an affiliate of a depository institution is pending, and insurance is offered or sold to the customer or is required in connection with the loan or extension of credit by the depository institution or affiliate of a depository institution, a written disclosure shall be provided to the customer indicating that the customer's choice of insurer or producer shall not affect the credit decision or credit terms in any way, except that the depository institution or an affiliate of a depository institution may impose reasonable requirements concerning the credit worthiness of the insurer and the scope of coverage chosen.

(ii) A rejection of a policy furnished by the customer shall not be deemed unreasonable if it is based on uniformly applied reasonable standards relating to the extent of coverage

required and the financial soundness and the services of an insurer. The standards shall not discriminate against any particular type of insurer, nor shall the standards call for rejection of a policy because it contains coverage in addition to that required in the credit transaction.

(C)(i)(a) The person, depository institution, or affiliate of the depository institution shall obtain written acknowledgement of the receipt of the disclosure required by this subdivision (1) from the customer at the time the customer receives the disclosure or at the time of the initial purchase of the insurance policy.

(b) If the solicitation is conducted by telephone, the person, depository institution, or affiliate of the depository institution shall obtain an oral acknowledgement of receipt of the disclosure, maintain sufficient documentation to show that the acknowledgment was given by the customer, and make reasonable efforts to obtain a written acknowledgment from the customer.

(ii) If a customer affirmatively consents to receiving the disclosures electronically and if the disclosures are provided in a format that the customer may retain or obtain later, the person, depository institution, or affiliate of the depository institution may provide the disclosure and obtain acknowledgement of the receipt of the disclosure from the customer using electronic media.

(D)(i) An affiliate of a depository institution is subject to the disclosure requirements of this subdivision (1) if it sells, solicits, advertises, or offers insurance products or annuities at an office of a depository institution or on behalf of a depository institution.

(ii) The disclosure requirements of this subdivision (1) apply only to a depository institution when an individual purchases, applies to purchase, or is solicited to purchase insurance products or annuities primarily for personal, family, or household purposes, and only to the extent that the disclosure would be accurate.

(E) For the purposes of this subdivision (1), a person sells, solicits, advertises, or offers insurance on behalf of a depository institution, whether at an office of the depository institution or another location, if at least one (1) of the following occurs:

(i) The person represents to the customer that the sale, solicitation, advertisement, or offer of the insurance is by or on behalf of a depository institution;

(ii) A depository institution refers a customer to the person who sells insurance, and the depository institution has a contractual arrangement to receive commissions or fees derived from the sale of insurance resulting from the referral; or

(iii) Documents evidencing the sale, solicitation, advertisement, or offer of insurance identify or refer to a depository institution; and

(2) Physical location of insurance activities. Insurance sales activities on depository institution or affiliate of a depository institution premises shall be conducted in a manner so as to minimize customer confusion by:

(A) Conducting the activities to the extent practicable in a location separate and distinct from the area where retail deposits routinely occur; and

(B) Where practicable, identifying the area where insurance activities are conducted with appropriate signage as to be easily distinguishable by the public as separate and distinct from deposit activities of the depository institution or affiliate of a depository institution.

No person, depository institution, or affiliate of a depository institution who lends money or extends credit may release, without the express consent of the customer, borrower, mortgagor, or purchaser:

(1) Insurance information of a customer relative to a policy which is required by the credit transaction, for the purpose of soliciting, selling, or replacing such insurance. This provision does not apply:

(A) In case of a transfer of insurance information to an unaffiliated insurer in connection with transferring insurance in force on an existing customer of the depository institution, or an affiliate thereof, or in connection with a merger with or acquisition of an unaffiliated insurer, or the release of information as otherwise authorized by state or federal law; and

(B) To the use or disclosure of insurance information to an officer, director, employee, agent, or affiliate of a depository institution; or

(2) Health information obtained from the insurance records of a customer for any purpose other than for its activities as a licensed producer.

23-66-608. Authorization to promulgate regulations.

The Insurance Commissioner may promulgate regulations to effectuate the purposes of this subchapter.

23-66-609. Prohibited activities.

No person, depository institution, or affiliate of a depository institution who lends money or extends credit may:

(1) Use an advertisement or other insurance promotional material that would cause a reasonable person to mistakenly believe that the federal government or the state is responsible for the insurance sales activity of or stands behind the credit of the person, depository institution, or its affiliate;

(2) Use an advertisement or other insurance promotional material that would cause a reasonable person to mistakenly believe that the federal government or the state guarantees any return on an insurance product or is a source of payment on any insurance obligation of or sold by the person, depository institution, or its affiliate;

(3) Solicit or sell insurance unless it maintains separate books and records relating to the insurance transactions, including all files relating to and reflecting consumer complaints; or

(4)(A) Pay or receive any commission, brokerage fee, or other compensation as a producer unless the person holds a valid producer's license for the applicable class of insurance.

(B) However, an unlicensed person may make a referral to a licensed producer provided that the person does not:

(i) Sell, solicit, or negotiate insurance;

(ii) Discuss specific insurance policy terms and conditions; or

(iii) Make recommendations or offer advice concerning insurance policies or coverages.

(C)(i) The unlicensed person may be compensated for the referral.

(ii) However, in the case of a referral of a customer, the unlicensed person may be compensated only if the compensation is a fixed dollar amount for each referral that does not depend on whether the customer purchases the insurance product from the licensed producer.

(D) Any person who accepts deposits from the public in an area where such transactions are routinely conducted in the depository institution may receive for each customer referral no more than a one-time, nominal fee of a fixed dollar amount for each referral that does not depend on whether the referral results in a transaction.

23-66-610. Commissioner's powers - Administrative proceedings.

(a) The Insurance Commissioner shall have the power to examine and investigate the insurance activities of depository institutions in order to determine whether a depository institution has been or is engaged in any unfair trade practice prohibited by this subchapter.

(b) The commissioner shall notify the appropriate bank regulatory agency of the commissioner's intent to examine or investigate a depository institution and advise the appropriate bank regulatory agency of the suspected violations of state law prior to commencing the examination or investigation.

(c) Administrative proceedings for persons not in compliance with this subchapter shall be held in accord with the procedures of §§ 23-66-209 - 23-66-213, subject to the following limitations or conditions:

(1)(A) If the person being investigated by the commissioner under subsection (a) of this section is a depository institution, the commissioner's authority to call a hearing for suspected violations of this subchapter is limited to the depository institution's insurance underwriting, sales, solicitation, and cross-marketing activities.

(B) The commissioner shall provide a copy of the notice of hearing to the appropriate bank regulatory agency when a depository institution is involved;

(2) If the person being investigated by the commissioner under subsection (a) of this section is a depository institution, the commissioner shall have the power to require the depository institution to produce books, papers, records, correspondence, or other documents that the commissioner deems relevant only to the inquiry regarding the insurance activities of the depository institution; and

(3) If practicable, the commissioner shall:

(A) Notify the appropriate bank regulatory agency before imposing a monetary penalty on a depository institution or suspending or revoking the depository institution's insurance license; and

(B) Provide to the appropriate bank regulatory agency a copy of the findings.

Subchapter 7.

Drug Enforcement Administration Registry Number Protection.

23-66-701. Legislative findings and intent.

The General Assembly hereby finds that registry numbers issued to physicians by the federal Drug Enforcement Administration are protected numbers not intended for use by insurance companies and health maintenance organizations. Pharmacists are prohibited by law from selling or dispensing controlled substances without a physician's Drug Enforcement Administration registry number, and disclosure of the registry number to insurers is unwarranted and inappropriate. The intent of this subchapter is to prohibit insurance companies and health maintenance organizations from requiring physicians, pharmacists, or others to disclose a physician's Drug Enforcement Administration registry number.

23-66-702. Drug Enforcement Administration registry numbers.

(a) Health carriers shall not require physicians, pharmacists, or other persons or entities to disclose a physician's Drug Enforcement Administration registry number for the purposes of identification, payment to a pharmacist, reimbursement of a patient, or any other reason.

(b) "Health carrier" means any insurance company or health maintenance organization subject to the following laws:

(1) The Arkansas Insurance Code;

(2) Section 23-76-101 et seq., pertaining to health maintenance organizations; and

(3) Any successor laws of the foregoing.

(c) Nothing in this section shall be construed to prohibit a health carrier, as part of the credentialing process, from requesting evidence that the physician has a valid Drug Enforcement Administration certificate.
