

## **Chapter 72.**

### **Mutual Assessment Life and Disability Insurers.**

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#### **23-72-101. Definitions.**

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

- (1) "Level or stipulated rate assessment" insurers are those incorporated mutual insurers granting insurance benefits on the assessment plan and which collected from their membership a level or stipulated monthly, quarterly, semiannual, or annual assessment or premium, which assessment or premium is not made contingent upon the happening of a certain event, but is based upon stated periodical rates and charges estimated to be sufficient for the payment of all claims and expenses; and
- (2) "Pro rata assessment" insurers are incorporated mutual insurers which operate on the plan of calling assessments to pay benefits promised when the contingency insured against arises and which place their membership in groups or circles for the purpose of assessment and collection of dues.

#### **23-72-102. Scope.**

- (a) This chapter applies only to domestic and foreign mutual insurers transacting life and disability insurance on the mutual assessment plan.
- (b) No provision of the Arkansas Insurance Code shall apply to such insurers unless

contained or referred to in this chapter.

**23-72-103. Other provisions applicable.**

In addition to the provisions contained in this chapter, other chapters and provisions of the Arkansas Insurance Code shall apply to mutual assessment life and disability insurers, to the extent so applicable, as follows:

- (1) Sections 23-60-101 - 23-60-108 and 23-60-110, scope of Arkansas Insurance Code;
- (2) Sections 23-61-101 et seq., 23-61-201 et seq., and 23-61-301 et seq., the Insurance Commissioner;
- (3) Sections 23-63-102 - 23-63-104, 23-63-201 - 23-63-216, 23-63-301, and 23-63-302, authorization of insurers and general requirements, with the exception of the following sections:
  - (A) Section 23-63-205, capital funds required;
  - (B) Section 23-63-207, special surplus requirement; and
  - (C) Section 23-63-206, bond or deposit requirement;
- (4) Applicable provisions of § 23-63-601 et seq., assets and liabilities;
- (5) Applicable provisions of § 23-63-801 et seq., investments;
- (6) Section 23-64-101 et seq., agents, brokers, and producers;
- (7) Section 23-65-101 et seq., unauthorized insurers;
- (8) Sections 23-66-201 - 23-66-214, 23-66-301 - 23-66-306, 23-66-308 - 23-66-311, 23-66-313, and 23-66-314, trade practice and frauds;
- (9) Sections 23-79-101 - 23-79-107, 23-79-109 - 23-79-128, 23-79-131 - 23-79-134, and 23-79-202 - 23-79-210, the insurance contract, except:
  - (A) Sections 23-79-131 - 23-79-134, exemption of proceeds;
  - (B) Section 23-79-204, venue; and
  - (C) Section 23-79-205, registered agents for service of process;
- (10) The following provisions of §§ 23-69-101 - 23-69-103, 23-69-105 - 23-69-141, 23-69-143, and 23-69-149 - 23-69-156, organization and corporate procedures of domestic stock and mutual insurers:
  - (A) Section 23-69-103, inapplicability of general corporation statutes;
  - (B) Section 23-69-107, amendment of articles of incorporation;
  - (C) Section 23-69-111, corporate powers in general;
  - (D) Section 23-69-111, contributions;
  - (E) Section 23-69-120, meetings of stockholders or members;
  - (F) Section 23-69-123, corrupt practices - penalty;
  - (G) Section 23-69-110, removal of director - vacancies;
  - (H) Section 23-69-108, officers;
  - (I) Section 23-69-109, prohibited pecuniary interest of officials;
  - (J) Section 23-69-134, home office and records and penalty for unlawful removal of records;
  - (K) Section 23-69-135, voucher for expenditures;
  - (L) Section 23-69-136, situs of personal property for taxation;

- (M) Section 23-69-137, management and exclusive agency contracts;
- (N) Sections 23-69-151 - 23-69-154, voluntary dissolution;
- (O) Section 23-69-155, mutual member's share of assets on liquidation; and
- (P) Section 23-69-156, extinguishment of unused corporate charters;
- (11) Applicable provisions of § 23-68-101 et seq., rehabilitation and liquidation; and
- (12) Section 23-62-205, reinsurance.

**23-72-104. Minimum requirements for new insurers.**

- (a) No insurer shall transact mutual assessment life or disability insurance in this state unless it lawfully had authority to transact the insurance on January 1, 1960, and provided further that from and after January 1, 1968, the insurer shall be required to:
  - (1) Maintain reserves on all life insurance policies, annuity and endowment contracts, and disability insurance policies issued on or after January 1, 1968, in the following manner:
    - (A) Reserves on all life insurance policies and annuity and endowment contracts shall be established and maintained in accordance with the provisions of the standard valuation law, § 23-84-101 et seq.; and
    - (B) Reserves on all accident and health insurance policies shall be established and maintained in accordance with the provisions of § 23-63-601 et seq.; and
  - (2) Insert in all life insurance policies and annuity and endowment contracts issued on and after January 1, 1968, a provision for nonforfeiture benefits in accordance with the standard nonforfeiture law, § 23-81-201 et seq.
- (b) No insurer shall continue to be authorized to transact mutual assessment life or disability insurance in this state unless it is otherwise entitled to such authority and has:
  - (1) At least two thousand (2,000) members regularly paying their assessments; and
  - (2) Surplus funds of at least ten thousand dollars (\$10,000).
- (c) No domestic insurer shall hereafter be organized to transact life or disability insurance on the mutual assessment plan.

**23-72-105. Bond.**

- (a) Every mutual assessment life and disability insurer shall have and maintain in force and on file with the Insurance Commissioner a bond in favor of the State of Arkansas in the sum of twenty thousand dollars (\$20,000), for the use of the policyholders of the insurer and their beneficiaries, with good and sufficient surety approved by the commissioner, and conditioned for the prompt payment of all assessments to parties or beneficiaries entitled thereto.
- (b) The makers of the bond shall continue to be liable thereon for any violation of the conditions thereof or for any loss accruing to the policyholders of the insurer or their beneficiaries.
- (c) The bond shall be renewable every two (2) years on March 1.
- (d) If at any time it appears that the bond has for any cause become insufficient, the commissioner may require the insurer to replace the bond on reasonable notice.

**23-72-106. Refusal, suspension, or revocation of certificate of authority.**

The Insurance Commissioner shall refuse to continue or shall suspend or revoke the certificate of authority of any such insurer for any of the following causes:

- (1) If, during the preceding calendar year, the insurer scaled and reduced its accrued beneficial claims by reason of insufficient yield of assessment or revenues;
- (2) If the insurer has exceeded its powers;
- (3) If the insurer has surplus of less than ten thousand dollars (\$10,000) or has fewer than two thousand (2,000) members regularly paying their assessments; or
- (4) For other causes specified in §§ 23-63-212 and 23-63-213.

**23-72-107. Pro rata or level assessment plans.**

- (a) Except as provided in § 23-72-118, a mutual assessment insurer may transact insurance on either the pro rata assessment plan only or on the level or stipulated rate plan only.
- (b) Each plan shall be governed by the provisions of this chapter made specifically applicable thereto and by those provisions applicable to both plans.

**23-72-108. Insuring powers.**

- (a) Mutual assessment insurers are prohibited from transacting any insurance except the granting of indemnity against or providing benefits upon death, disability, or accident.
- (b) No mutual assessment insurer shall transact property, casualty, surety, or industrial insurance.
- (c) For the purposes of this chapter, an "industrial insurer" is an insurer which issues policies granting life, health, and accident indemnities, basing the benefits promised on the payment by the policyholder of a stipulated weekly premium.

**23-72-109. Bylaws generally.**

- (a) The insurer shall have bylaws which are not in conflict with the law of this state, to regulate and govern its affairs. Bylaws of both foreign and domestic insurers shall be subject to the applicable requirements of § 23-69-119.
- (b) The bylaws shall provide for periodic meetings of the members and how special meetings may be called. At all meetings each member shall be entitled to one (1) vote only on each question coming to a vote. The member may vote in person or by written proxy, and the proxy may be given in the application for membership. No proxy shall be irrevocable.
- (c) The bylaws may provide for issuance of graded membership certificates and for the grading of rates and assessments according to the ages of members.
- (d) If disability benefits are promised in membership certificates, adequate provisions shall be made in the bylaws for assessments to pay disability claims and expenses incident thereto, and the assessments shall not be used for the payment of claims other than disability.
- (e) Every member of the insurer is bound by the insurer's bylaws as in existence at the time of joining or as thereafter amended.

**23-72-110. Filing and amendment of bylaws.**

- (a) The insurer shall promptly file a copy of its bylaws, duly certified by its president and secretary, with the Insurance Commissioner.
- (b) No amendment of bylaws shall be valid and binding upon the insurer's members until a certified copy of the amendment has been on file with the commissioner for a period of at least ten (10) days.
- (c) No amendment of an insurer's bylaws affecting rates shall be effective unless and until approved by the commissioner as being reasonable or necessary.

**23-72-111. Special provisions of pro rata assessment plan.**

In addition to the requirements under § 23-72-109, the bylaws of a pro rata assessment plan insurer:

- (1) Shall clearly provide the plan of calling assessments. They may provide for assessment of each group or circle for payment of its own claims, for the assessing of groups or circles in rotation, or for assessing any group or circle, or the entire membership, for the payment of any matured claim; and
- (2) May provide for the collection of assessments in advance to be used for the payment of claims and expenses.

**23-72-112. Additional assessments or adjustments of rates or benefits.**

An insurer has power to provide in its bylaws for the calling of extra, increased, or additional assessments or for adjustment of rates and benefits when the assessments and contributions from its members prove to be inadequate to meet all claims and expenses.

**23-72-113. Benefits and payment - Level or stipulated plan insurers.**

- (a) A level or stipulated rate plan insurer shall specify in its policy or membership certificate the contingencies insured against, the sum of money it promises to pay or the benefits it agrees to provide, and the number of days after satisfactory proof of loss is filed within which the payment will be made or the benefit will be provided.
- (b) Upon the occurrence of a contingency insured against, unless the contract has been voided by fraud or by breach of its conditions, the insurer shall be obligated to the beneficiary for payment of or providing benefits at the time and in the amount or value specified in the policy or certificate.
- (c) If the insurer fails to make the payment after final judgment has been obtained upon the claim, the Insurance Commissioner shall notify the insurer not to issue any new policy or certificates until the indebtedness is fully paid. No officer or agent of the insurer shall issue any policy or certificate while the notice is in force. In addition, the insurer's certificate of authority shall be subject to suspension or revocation under § 23-63-213.

**23-72-114. Benefits not subject to attachment.**

No money or other benefits to be paid, provided, or rendered by any insurer, not to exceed one thousand dollars (\$1,000), shall be liable to attachment, garnishment, or other process, or be seized, taken, appropriated, or applied by any legal or equitable process or

operation of law to pay any debt or liability of any member or beneficiary, or any other person who may have a right thereunder, either before or after payment.

**23-72-115. Notice to members of scaled and reduced claims.**

- (a) Each insurer shall, on or before March 1 as to the preceding calendar year, give written notice thereof by mail to those of its members whose status and conditions of certificate or policy are similar, if the insurer has scaled and reduced its beneficial claims for the preceding year.
- (b) The notice shall contain the names and addresses of the deceased members, the accrued or face value of the certificate, and the amount received by the beneficiary and shall only include all those scaled or reduced claims by reason of insufficient yield of assessments or revenue apportioned to the settlement of such claims.
- (c) The notice shall have printed thereon as a heading in bold face type of not less than eighteen (18) points the words: "NOTICE AND WARNING".

**23-72-116. Pro rata plan insurer - Reclassification and rearrangement of members.**

A pro rata assessment plan insurer has power at any time to reclassify, transfer, or rearrange its members, to merge or unite circles or groups; and to unite into one (1) group or circle two (2) or more groups or circles, the membership of which has decreased below the maximum. The insurer shall not start a new group or circle so long as any other group or circle is not up to maximum. All groups and circles shall be kept up to the maximum.

**23-72-117. Reinsurance.**

- (a) A mutual assessment insurer may reinsure in any authorized life insurer any single risk or part of any single risk which it may assume.
- (b) The insurer may reinsure all or substantially all of its insurance in force by reinsurance in bulk as provided for in § 23-72-119.

**23-72-118. Conversion to level premium plan.**

- (a) A pro rata assessment insurer, by resolution of its board of directors approved by the Insurance Commissioner, may convert the whole or any part of its membership into a level or stipulated rate division. Thereafter, laws applicable to a level or stipulated rate insurer shall apply and govern the insurer or division so converted.
- (b) The insurer shall segregate the funds and income of the two (2) classes and not intermingle funds where the insurer is operating on a pro rata assessment basis and with a division on a level or stipulated rate assessment basis.

**23-72-119. Merger or bulk reinsurance or conversion.**

- (a)(1) Any mutual assessment domestic insurer may merge or reinsure its outstanding policies in bulk with any domestic stipulated premium insurer operating under § 23-71-101 et seq. and, upon filing with the Insurance Commissioner, an agreement setting out the conditions of the proposed merger or bulk reinsurance, and certifying that the agreement has been approved by the boards of directors of the respective

merging insurers, together with a financial statement of each such insurer.

- (2) The merger shall be subject to the commissioner's approval, in accordance with the same standards as are stated in § 23-69-143.
  - (3) Upon approval, the membership or policyholders of the merged insurers are bound in all respects by the merger agreement as approved by the commissioner.
- (b) The domestic insurer may consolidate, merge, or bulk reinsure with any solvent legal reserve life insurer by proper resolution of its board of directors and pursuant to the commissioner's approval and applicable procedure provided by §§ 23-69-143 - 23-69-145, except that approval of the plans or agreement of merger or bulk reinsurance by members of any insurer involved may be dispensed with if the plan or agreement is otherwise approved by the commissioner.
- (c) A domestic insurer may convert into a legal reserve stock insurer under the procedures and conditions provided by § 23-69-141, but the insurer shall be subject to minimum capital stock and maximum risk requirement as provided in § 23-71-116 for stipulated premium plan insurers and to subdivisions (d)(3), (4), and (6) of this section.
- (d) A domestic insurer may convert to a legal reserve mutual insurer under a plan filed with and approved by the commissioner as being reasonable, appropriate, and not injurious to the protection or interests of present or future policyholders of the insurer, subject to the following conditions:
- (1) The insurer's articles of incorporation shall be amended to provide for transaction of business on the mutual legal reserve basis;
  - (2) When first so converted, the insurer shall have surplus funds of not less than fifty thousand dollars (\$50,000). At the end of the fifth calendar year next succeeding the calendar year in which the insurer was so converted, its surplus shall be not less than seventy-five thousand dollars (\$75,000). At the end of the tenth and subsequent calendar years, its surplus shall be not less than one hundred thousand dollars (\$100,000);
  - (3) The insurer shall write no new business on the assessment plan or reinstate any such business theretofore lapsed following the date of conversion;
  - (4) Assessment plan business in force on the date of conversion may continue in force on the same plan. However, the insurer shall maintain separate accounts of its assessment plan business and its legal reserve business;
  - (5) The maximum single risk retained by the insurer after conversion shall not exceed five percent (5%) of the insurer's surplus, until the surplus totals to one hundred thousand dollars (\$100,000) or more; and
  - (6) After conversion the insurer shall otherwise have the same powers and obligations as like legal reserve insurers under the Arkansas Insurance Code.

#### **23-72-120. Venue and service of process.**

- (a) Any action by a policy or certificate holder or beneficiary against an insurer or against its bond or bondsmen on any claim arising or accruing under any of its policies or certificates may be brought in any county in this state where the plaintiff, or any plaintiff in the action, may reside.
- (b) If the action is against the insurer, service of summons or process may be made on

the secretary or president or managing agent of the insurer.

- (c) If the action is against the bond or bondsmen of the insurer, service of summons or process may be made by ordinary service as in other cases upon the several bondsmen sued.
- (d) In the action it shall not be necessary to notify or summon other policyholders or beneficiaries.
- (e) In the action against a foreign corporation, service of summons or process may be made upon the corporation by service of summons or process upon the registered agent pursuant to §§ 23-63-301 - 23-63-304 or pursuant to methods specified in other laws or rules on and after January 1, 2003.

**23-72-121. Insolvency.**

An insurer is insolvent when its reserves, its matured death claims, and its other due and unpaid obligations exceed its assets and death assessments or periodic payments called, to be called, or in process of collection.

**History.** Acts 1959, No. 148, § 576; 1967, No. 393, § 4; A.S.A. 1947, § 66-4521.

**23-72-122. Officers and members not individually liable.**

Officers and members of a domestic insurer shall not be individually liable for the payment of any disability or death benefit provided for in the bylaws and agreements of the insurer, but the benefit shall be payable out of the funds of the insurer and in the manner provided by its bylaws.