

Chapter 96.
Arkansas Life and Health Insurance Guaranty Association Act.

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23-96-101. Title.

This chapter shall be known and cited as the "Arkansas Life and Health Insurance Guaranty Association Act".

23-96-102. Purpose.

- A. The purpose of this chapter is to protect, subject to certain limitations, the persons specified in § 23-96-107(A) against failure in the performance of contractual obligations under life and accident and health insurance policies and annuity contracts specified in § 23-96-107(B) because of the impairment or insolvency of the member insurer that issued the policies or contracts.
 - B. To provide this protection, an association of insurers is created to pay benefits and to continue coverages as limited herein, and members of the association are subject to assessment to provide funds to carry out the purpose of this chapter.
- The 2001 amendment, in A, substituted "accident and health" for "disability."

23-96-103. Construction - Applicability.

- A. This chapter shall be construed to effect the purpose under § 23-96-102.
- B. Nothing in this chapter shall be construed to reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

23-96-104. Definitions.

As used in this chapter:

- A. "Account" means any of the two (2) accounts created under § 23- 96-109.
- B. "Association" means the Arkansas Life and Health Insurance Guaranty Association created under § 23-96-109.
- C. "Authorized assessment" or the term "authorized" when used in the context of assessments means a resolution by the board of directors has been passed whereby an assessment will be called immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution is passed.
- D. "Benefit plan" means a specific employee, union or association of natural persons benefit plan.
- E. "Called assessment" or the term "called" when used in the context of assessments means that a notice has been issued by the Association to member insurers requiring that an authorized assessment be paid within the time frame set forth within the notice. An authorized assessment becomes a called assessment when notice is mailed by the Association to member insurers.
- F. "Commissioner" means the Insurance Commissioner of this state.
- G. "Contractual obligations" means any obligation under a policy or contract or certificate under a group policy or contract, or portion thereof for which coverage is provided under § 23-96-107.
- H. "Covered policy" or "covered contract" means any policy or contract or portion of a policy or contract for which coverage is provided under § 23-96-107.
- I. "Extra-contractual claims" shall include, for example, claims relating to bad faith in the payment of claims, punitive or exemplary damages or attorneys' fees and costs.
- J. "Impaired insurer" means a member insurer which, after March 9, 1989, is not an insolvent insurer and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.
- K. "Insolvent insurer" means a member insurer which, after March 9, 1989, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.
- L. "Member insurer" means any insurer licensed or which holds a certificate of authority to transact in this state any kind of insurance for which coverage is provided under § 23-96-107, and includes any insurer whose license or certificate of authority in this state may have been suspended, revoked, not renewed, or voluntarily withdrawn, but does not include:
 - (1) A hospital or medical service organization, whether profit or nonprofit;
 - (2) A health maintenance organization;
 - (3) A fraternal benefit society;
 - (4) A mandatory state pooling plan;

- (5) A burial association;
- (6) An insurance exchange;
- (7) Prepaid funeral trusts;
- (8) An organization which has a certificate or license limited to the issuance of charitable gift annuities; or
- (9) Any entity similar to any of the above.

M. "Moody's Corporate Bond Yield Average" means the Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto.

N. "Owner" of a policy or contract and "policy owner" and "contract owner" means the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the insurer. The terms "owner", "contract owner" and "policy owner" do not include persons with a mere beneficial interest in a policy or contract.

O.(1) "Person" means any individual, corporation, limited liability company, partnership, association, governmental body or entity, or voluntary organization.

(2) It is the intent of the General Assembly that the term "person" shall include a claimant or beneficiary who is receiving annuity benefits as provided in § 11-9-210 and § 23-96-114(F) and (B).

P. "Plan sponsor" means:

- (1) The employer in the case of a benefit plan established or maintained by a single employer;
- (2) The employee organization in the case of a benefit plan established or maintained by an employee organization; or
- (3) In a case of a benefit plan established or maintained by two (2) or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan.

Q.(1) "Premiums" means amounts or considerations (by whatever name called) received on covered policies or contracts less returned premiums, considerations, and deposits and less dividends and experience credits.

(2)(a) "Premiums" does not include amounts or considerations received for any policies or contracts or for the portions of policies or contracts for which coverage is not provided under § 23-96-106, except that assessable premium shall not be reduced on account of § 23-96-106(A)(3), relating to interest limitations and § 23-96-114(A)(2), relating to limitations with respect to one individual, one participant, and one contract owner.

(b) Provided, "premiums" shall not include:

- (i) Any premiums in excess of one million dollars (\$1,000,000) on an unallocated annuity contract not issued under a governmental retirement benefit plan (or its trustee) established under Sections 401(k), 403(b), or 457 of the United States Internal Revenue Code; or
- (ii) With respect to multiple non-group policies of life insurance owned by one owner, whether the policy owner is an individual, firm, corporation or

other person, and whether the persons insured are officers, managers, employees or other persons, premiums in excess of one million dollars (\$1,000,000) with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.

R.(1) "Principal place of business" of a plan sponsor or a person other than a natural person means the single state in which the natural persons who establish policy for the direction, control and coordination of the operations of the entity as a whole primarily exercise that function, determined by the Association in its reasonable judgment by considering the following factors:

(a) The state in which the primary executive and administrative headquarters of the entity is located;

(b) The state in which the principal office of the chief executive officer of the entity is located;

(c) The state in which the board of directors (or similar governing person or persons) of the entity conducts the majority of its meetings;

(d) The state in which the executive or management committee of the board of directors (or similar governing person or persons) of the entity conducts the majority of its meetings;

(e) The state from which the management of the overall operations of the entity is directed; and

(f) In the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the above factors. However, in the case of a plan sponsor, if more than fifty percent (50%) of the participants in the benefit plan are employed in a single state, that state shall be deemed to be the principal place of business of the plan sponsor.

(2) The principal place of business of a plan sponsor of a benefit plan described in Subsection P(3) of this section shall be deemed to be the principal place of business of the association, committee, joint board of trustees or other similar group of representatives of the parties who establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, shall be deemed to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question.

- S. "Receivership court" means the court in the insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation or liquidation of the insurer.
- T. "Resident" means a person to whom a contractual obligation is owed and who resides in this state on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer, whichever occurs first. A person may be a resident of only one state, which in the case of a person other than a natural person shall be its principal place of business. Citizens of the United States that are either (i) residents of foreign countries, or (ii) residents of United States possessions, territories or protectorates that do not have an association similar to the Association created by this chapter shall be deemed residents of the state of domicile of the insurer that issued the policies or

contracts.

- U. "Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.
- V. "State" means a state, the District of Columbia, Puerto Rico, and a United States possession, territory or protectorate.
- W. "Supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, an accident and health, or an annuity policy or contract.
 - X.(1) "Unallocated annuity contract" means an annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under such contract or certificate.
 - (2) It is the intent of the General Assembly that an annuity contract as provided for in § 11-9-210, shall not be an "unallocated annuity contract".

23-96-105. Advertisement of association act in insurance sales - Notice to policy owners.

- A. No person, including an insurer, agent, or affiliate of an insurer shall make, publish, disseminate, circulate, or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in any newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station or television station, or in any other way, any advertisement, announcement, or statement, written or oral, which uses the existence of the Arkansas Life and Health Insurance Guaranty Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance covered by this chapter, except in conformity with the rules and regulations of the commissioner. In adopting such rules and regulations, the commissioner, in consultation with the board of directors of the Association, shall take into consideration the following factors: the need of the public to have confidence in the financial soundness of insurance products offered for sale in this state, the financial integrity of member insurers doing business in this state, and the role of the Association in serving as a safety net for policyowners, contract owners, insureds and beneficiaries of impaired or insolvent insurers in this state. Provided, however, that this section shall not apply to the Arkansas Life and Health Insurance Guaranty Association or any other entity which does not sell or solicit insurance.
 - B.(1)(a) Within one hundred eighty (180) days of March 9, 1989, the Association shall prepare a summary document describing the general purpose and current limitations of the chapter and complying with Subsection C of this section.
 - (b) This document shall be submitted to the commissioner for approval.
 - (c) Sixty (60) days after receiving such approval, no insurer may deliver a policy or contract described in § 23-96-107(B) to a policy or contract owner unless the summary document is delivered to the policy or contract owner at the time of delivery of the policy or contract except if § 23-96-107(C) applies.
 - (2)(a) The document should also be available upon request by a policy owner.
 - (b) The distribution, delivery, or contents or interpretation of this document does not guarantee that either the policy or the contract or the owner thereof is

covered in the event of the impairment or insolvency of a member insurer.

(c) The description document shall be revised by the association as amendments to this chapter may require.

(d) Failure to receive this document does not give the policy owner, contract owner, certificate holder, or insured any greater rights than those stated in this chapter.

C.(1) The document prepared under Subsection B of this section shall contain a clear and conspicuous disclaimer on its face.

(2) The commissioner shall establish the form and content of the disclaimer.

(3) The disclaimer shall:

(a) State the name and address of the Arkansas Life and Health Insurance Guaranty Association and State Insurance Department;

(b) Prominently warn the policy or contract owner that the Arkansas Life and Health Insurance Guaranty Association may not cover the policy or, if coverage is available, it will be subject to substantial limitations, exclusions, and conditioned on continued residence in this state;

(c) State the types of policies for which guaranty funds will provide coverage;

(d) State that the insurer and its agents are prohibited by law from using the existence of the Arkansas Life and Health Insurance Guaranty Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance;

(e) State that the policy or contract owner should not rely on coverage under the Arkansas Life and Health Insurance Guaranty Association when selecting an insurer;

(f) Explain rights available and procedures for filing a complaint to a violation of any provisions of this chapter; and

(g) Provide other information as directed by the commissioner including but not limited to, sources of information about financial conditions of insurers provided that the information is not proprietary and is subject to disclosure under that state's public records law.

23-96-106. Scope of chapter.

A. This chapter shall not provide coverage for:

(1) A portion of a policy or contract not guaranteed by the insurer, or under which the risk is borne by the policy or contract owner;

(2) A portion of a policy or contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract;

(3) A policy or contract to the extent that the rate of interest on which it is based, or the interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value:

(a) Averaged over the period of four (4) years prior to the date on which the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier, exceeds a rate of interest determined by subtracting two (2) percentage points from Moody's Corporate Bond Yield Average averaged for that same four-year period or for such lesser period if the policy or contract was issued less than four (4) years before the member insurer becomes an impaired or

insolvent insurer under this chapter, whichever is earlier; and

- (b) On and after the date on which the association becomes obligated with respect to such policy or contract, exceeds the rate of interest determined by subtracting three (3) percentage points from Moody's Corporate Bond Yield Average as most recently available;
- (4) A portion of a policy or contract issued to a plan or program of an employer, association, or other person to provide life, accident and health, or annuity benefits to its employees, members or others to the extent that such plan or program is self-funded or uninsured, including but not limited to benefits payable by an employer, association, or other person under
 - (a) A multiple employer welfare arrangement as defined in Section 514 of the Employee Retirement Income Security Act of 1974, as amended;
 - (b) A minimum premium group insurance plan;
 - (c) A stop-loss group insurance plan; or
 - (d) An administrative services only contract;
- (5) A portion of a policy or contract to the extent that it provides for dividends or experience rating credits, voting rights, or payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of such policy or contract;
- (6) A policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue such policy or contract in this state;
- (7) An unallocated annuity contract issued to or in connection with a benefit plan protected under the federal Pension Benefit Guaranty Corporation regardless of whether the federal Pension Benefit Guaranty Corporation has yet become liable to make any payments with respect to the benefit plan;
- (8) A portion of an unallocated annuity contract that is not owned by a benefit plan (directly or in trust) or a government lottery or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution;
- (9) Any policy or contract written on the mutual assessment plan or stipulated premium plan prior to January 1, 1968, for which no statutory legal reserves are required;
- (10) A portion of a policy or contract to the extent that the assessments required by § 23-96-115 with respect to the policy or contract are preempted by federal or state law;
- (11) An obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the contract owner or policy owner, including without limitation:
 - (a) Claims based on marketing materials;
 - (b) Claims based on side letters, riders or other documents that were issued by the insurer without meeting applicable policy form filing or approval requirements;
 - (c) Misrepresentations of or regarding policy benefits;
 - (d) Extra-contractual claims; or
 - (e) A claim for penalties or consequential or incidental damages; and

- (12) A contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustees, which in each case is not an affiliate of the member insurer.
- B. The protection provided by this chapter shall not apply where any guaranty protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state.

23-96-107. Coverage.

- A. This chapter shall provide coverage for the policies and contracts specified in Subsection B of this section to:
- (1) Persons who, regardless of where they reside, except for nonresident certificate holders under group policies or contracts, are the beneficiaries, assignees, or payees of the persons covered under Paragraph (2) of this section;
 - (2) Persons who are owners of or certificate holders under such policies or contracts (other than unallocated annuity contracts and structured settlement annuities) and in each case who:
 - (a) Are residents; or
 - (b) Are not residents, but only under all of the following conditions:
 - (i) The insurer that issued the policies or contracts is domiciled in this state;
 - (ii) The states in which the persons reside have associations similar to the association created by this chapter;
 - (iii) The persons are not eligible for coverage by an association in any other state due to the fact that the insurer was not licensed in the state at the time specified in the state's guaranty association law.
 - (3) For unallocated annuity contracts specified in Subsection B, Paragraphs (1) and (2) of this subsection shall not apply and this chapter shall (except as provided in Paragraphs (5) and (6) of this subsection) provide coverage to:
 - (a) Persons who are the owners of the unallocated annuity contracts if such contracts are issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of business in this state; and
 - (b) Persons who are owners of unallocated annuity contracts issued to or in connection with government lotteries if the owners are residents.
 - (4) For structured settlement annuities specified in Subsection B, Paragraphs (1) and (2) of this subsection shall not apply, and this chapter shall (except as provided in Paragraphs (5) and (6) of this subsection) provide coverage to a person who is a payee under a structured settlement annuity (or beneficiary of a payee if the payee is deceased), if the payee:
 - (a) Is a resident, regardless of where the contract owner resides, or
 - (b) Is not a resident, but only under both of the following conditions:
 - (i) The contract owner of the structured settlement annuity is a resident, or
 - (ii) The contract owner of the structured settlement annuity is not a resident, but the insurer that issued the structured settlement annuity is domiciled in this state;
 - (iii) The state in which the contract owner resides has an association similar to

the association created by this chapter; and

(ii) Neither the payee (or beneficiary) nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides.

(5) This chapter shall not provide coverage for:

(a) A person who is a payee (or beneficiary) of a contract owner resident of this state, if the payee (or beneficiary) is afforded any coverage by the association of another state; or

(b) A person covered in Paragraph A(3) of this section if any coverage is provided by the association of another state to such person.

(6) This chapter is intended to provide coverage to a person who is a resident of this state and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this chapter is provided coverage under the laws of any other state, the person shall not be provided coverage under this chapter. In determining the application of the provision of this subdivision in situations where a person could be covered by the association of more than one state, whether as an owner, payee, beneficiary or assignee, this chapter shall be construed in conjunction with other state laws to result in coverage by only one association.

B. This chapter shall provide coverage to the persons specified in Subsection A for direct, nongroup life, accident and health or annuity policies or contracts, and supplemental contracts to any of these, for certificates under direct group policies and contracts, and for unallocated annuity contracts issued by member insurers, except as limited by this chapter. Annuity contracts and certificates under group annuity contracts include but are not limited to guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement annuities, annuities issued to or in connection with government lotteries and any immediate or deferred annuity contracts.

C.(1) No insurer or agent may deliver a policy or contract described in Subsection B of this section and excluded under § 23-96-106(A)(1) from coverage under this chapter unless the insurer or agent, prior to or at the time of delivery, gives the policy or contract holder a separate written notice which clearly and conspicuously discloses that the policy or contract is not covered by the Arkansas Life and Health Insurance Guaranty Association.

(2) The commissioner shall by rule specify the form and content of the notice.

23-96-108. Immunity.

There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer or its agents or employees, the Association or its agents or employees, members of the board of directors, or the commissioner or his representatives for any action or omission by them in the performance of their powers and duties under this chapter. Such immunity shall extend to the participation in any organization of one or more other state associations of similar purposes and to any such organization and its agents or employees.

23-96-109. Creation of the association - Examination - Annual report - Tax

exemption - Board of directors.

A.(1) There is created a nonprofit legal entity to be known as the "Arkansas Life and Health Insurance Guaranty Association". All member insurers shall be and remain members of the Association as a condition of their authority to transact insurance in this state. The association shall perform its functions under the plan of operation established and approved under § 23-96-116 and shall exercise its powers through a board of directors established under Subsection B of this section.

- (2) The Association shall come under the immediate supervision of the commissioner and shall be subject to the applicable provisions of the insurance laws of this state. Meetings or records of the Association may be opened to the public upon majority vote of the board of directors of the association.
- (3) The Association shall be subject to examination and regulation by the commissioner.
- (4) The board of directors shall submit to the commissioner each year, not later than one hundred twenty (120) days after the Association's fiscal year, a financial report in a form approved by the commissioner and a report of its activities during the preceding fiscal year. Upon request of a member insurer, the Association shall provide the member insurer with a copy of the report.
- (5) For purposes of administration and assessment the Association shall maintain two (2) accounts:
 - (a) The life insurance and annuity account, which includes the following subaccounts:
 - (i) Life insurance account;
 - (ii) Annuity account which shall include annuity contracts owned by a governmental retirement plan (or its trustee) established under Sections 401(k), 403(b) or 457 of the United States Internal Revenue Code, but shall otherwise exclude unallocated annuities; and
 - (iii) Unallocated annuity account, which shall exclude contracts owned by a governmental retirement benefit plan (or its trustee) established under Section 401(k), 403(b) or 457 of the United States Internal Revenue Code;
 - (b) The accident and health insurance account.
- (6) The Association shall be exempt from payment of all fees and all taxes levied by this state or any of its subdivisions, except taxes levied on real property.

B.(1)(a) The board of directors of the Association shall consist of not less than five (5) nor more than nine (9) member insurers serving terms as established in the plan of operation.

(b) The members of the board shall be selected by member insurers subject to the approval of the commissioner.

(c) Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining board members, subject to the approval of the commissioner.

- (2) In approving selections to the board, the commissioner shall consider, among other things, whether all member insurers are fairly represented.
- (3) Members of the board may be reimbursed from the assets of the Association for expenses incurred by them as members of the board of directors, but members of

the board shall not otherwise be compensated by the Association for their services.

23-96-110. Powers and duties of association.

- A. In addition to the rights and powers elsewhere in this chapter, the Association may:
- (1) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this chapter;
 - (2) Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under § 23-96-115 and to settle claims or potential claims against it;
 - (3) Borrow money to effect the purposes of this chapter. Any notes or other evidence of indebtedness of the Association not in default shall be legal investments for domestic insurers and may be carried as admitted assets;
 - (4) Employ or retain such persons as are necessary or appropriate to handle the financial transactions of the Association and to perform such other functions as become necessary or proper under this chapter;
 - (5) Take such legal action as may be necessary or appropriate to avoid or recover payment of improper claims;
 - (6) Exercise, for the purpose of this chapter and to the extent approved by the commissioner, the powers of a domestic life or accident and health insurer, but in no case may the Association issue insurance policies or annuity contracts other than those issued to perform its obligations under this chapter;
 - (7) Organize itself as a corporation or in other legal form permitted by the laws of this state;
 - (8) Request information from a person seeking coverage from the Association in order to aid the Association in determining its obligations under this chapter with respect to the person, and the person shall promptly comply with the request; and
 - (9) Take other necessary or appropriate action to discharge its duties and obligations under this chapter or to exercise its powers under this chapter.
- B. The Association may render assistance and advice to the commissioner, upon his request, concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of any impaired or insolvent insurer.
- C.(1) The association shall have standing to appear or intervene before any court or agency in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this chapter or with jurisdiction over any person or property against whom the association may have rights through subrogation or otherwise. Provided, at its option, the association may appear solely for the purpose of receiving copies of all pleadings and notices and attending hearings without otherwise becoming a party to the proceeding. Such standing shall extend to all matters germane to the powers and duties of the association, including, but not limited to, proposals for reinsuring, modifying, or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations.
- (2) The Association shall also have the right to appear or intervene before a court or agency in another state with jurisdiction over an impaired or insolvent insurer for

which the association is or may become obligated or with jurisdiction over any person or property against whom the association may have rights through subrogation or otherwise.

- D. The Association may join an organization of one (1) or more other state associations of similar purposes, to further the purposes and administer the powers and duties of the association.

E.(1)(a) Records shall be kept of all meetings of the board of directors to discuss the activities of the association in carrying out its powers and duties under §§ 23-96-111 - 23-96-114, and 23-96-120.

(b) The records of the Association with respect to an impaired or insolvent insurer shall not be disclosed prior to the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer, upon the termination of the impairment or insolvency of the insurer, or upon the order of a court of competent jurisdiction.

(2) Nothing in this subsection shall limit the duty of the Association to render a report of its activities under § 23-96-109(A)(4).

- F. At any time within one year after the date on which the Association becomes responsible for the obligations of a member insurer (the coverage date), the Association may elect to succeed to the rights and obligations of the member insurer, that accrue on or after the coverage date and that relate to contracts covered (in whole or in part) by the Association, under any one or more indemnity reinsurance agreement(s) entered into by the member insurer as a ceding insurer and selected by the Association; provided, however, that the Association may not exercise any such election with respect to a reinsurance agreement if the receiver, rehabilitator or liquidator of the member insurer has previously and expressly disaffirmed the reinsurance agreement. The election shall be effected by a notice to the receiver, rehabilitator or liquidator and to the affected reinsurer(s). If the Association makes an election, Paragraphs F(1) through F(4) of this section shall apply with respect to the agreements selected by the Association:

(1) The Association shall be responsible for all unpaid premiums due under the agreement(s) (for periods both before and after the coverage date), and shall be responsible for the performance of all other obligations to be performed after the coverage date, in each case which relate to contracts covered (in whole or in part) by the Association. The association may charge contracts covered in part by the Association through reasonable allocation methods, the costs for reinsurance in excess of the obligations of the Association;

(2) The Association shall be entitled to any amounts payable by the reinsurer under the agreement(s) with respect to losses or events that occur in periods after the coverage date and that relate to contracts covered by the Association (in whole or in part), provided that, upon receipt of any such amounts, the Association shall be obliged to pay to the beneficiary under the policy or contract on account of which the amounts were paid a portion of the amount equal to the excess of:

(a) The amount received by the Association; or

(b) The benefits paid by the Association on account of the policy or contract less the retention of the impaired or insolvent member insurer applicable to the loss or event;

- (3) Within thirty (30) days following the Association's election, the Association and each indemnity reinsurer shall calculate the net balance due to or from the Association under each such reinsurance agreement(s) as of the date of the Association's election, which calculation shall give full credit to all items paid by either the member insurer (or its receiver, rehabilitator or liquidator) or the indemnity reinsurer during the period between the coverage date and the date of the Association's election. Either the Association or indemnity reinsurer shall pay the net balance due the other within five (5) days of the completion of the aforementioned calculation. If the receiver, rehabilitator or liquidator has received any amounts due the Association pursuant to Paragraph F(2) of this section, the receiver, rehabilitator or liquidator shall remit the same to the Association as promptly as practicable.
 - (4) If the Association, within sixty (60) days of the election, pays the premiums due for period both before and after the coverage date that relates to contracts covered by the Association (in whole or in part), the reinsurer shall not be entitled to terminate the reinsurance agreement(s) (insofar as the agreement(s)) relate to contracts covered by the Association (in whole or in part) and shall not be entitled to set off any unpaid premium due for periods prior to the coverage date against amounts due the Association.
- G. In the event the Association transfers its obligations to another insurer, and if the Association and the other insurer agree, the other insurer shall succeed to the rights and obligations of the Association under Subsection F of this section effective as of the date agreed upon by the Association and the other insurer and regardless of whether the Association has made the election referred to above in Subsection F provided that:
- (1) the indemnity reinsurance agreement(s) shall automatically terminate for new reinsurance unless the indemnity reinsurer and the other insurer agree to the contrary;
 - (2) the obligations described in the proviso to Paragraph F(2) of this section shall no longer apply on and after the date the indemnity reinsurance agreement is transferred to the third party insurer; and
 - (3) this Subsection G shall not apply if the Association has previously expressly determined in writing that it will not exercise the election referred to in Subsection F of this section.
- H. The provisions of Subsection F of this section shall supersede the provisions of any law of this state or of any affected reinsurance agreement(s) that provide for or require any payment of reinsurance proceeds, on account of losses or events that occur in periods after the coverage date, to the receiver, liquidator or rehabilitator of the insolvent member insurer. The receiver, rehabilitator or liquidator shall remain entitled to any amounts payable by the reinsurer under the reinsurance agreement(s) with respect to losses or events that occur in periods prior to the coverage date (subject to applicable setoff provisions).
- I. Except as otherwise expressly provided above, nothing herein shall alter or modify the terms and conditions of the indemnity reinsurance agreements of the insolvent member insurer. Nothing herein shall abrogate or limit any rights of any reinsurer to claim that is entitled to rescind a reinsurance agreement. Nothing herein shall give a

policy owner or beneficiary an independent cause of action against an indemnity reinsurer that is not otherwise set forth in the indemnity reinsurance agreement.

- J. The board of directors of the Association shall have discretion and may exercise reasonable business judgment to determine the means by which the Association is to provide the benefits of this chapter in an economical and efficient manner and may provide additional or alternative coverages and benefits in appropriate situations.
- K. Where the Association has arranged or offered to provide the benefits of this chapter to a covered person under a plan or arrangement that fulfills the Association's obligations under this chapter, the person shall not be entitled to benefits from the Association in addition to or other than those provided under the plan or arrangement.
- L. Venue in a suit against the Association arising under this chapter shall be in Pulaski County. The Association shall not be required to give an appeal bond in an appeal that relates to a cause of action arising under this chapter.

23-96-111. Impaired insurers.

If a member insurer is an impaired insurer, the Association may, in its discretion and subject to any conditions imposed by the Association that do not impair the contractual obligations of the impaired insurer and that are approved by commissioner:

- (1) Guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, any or all of the policies or contracts of the impaired insurer; or
- (2) Provide such moneys, pledges, loans, notes, guarantees, or other means as are proper to effectuate Paragraph (1) of this section and assure payment of the contractual obligations of the impaired insurer pending action under Paragraph (1) of this section.

23-96-112. Insolvent insurers.

- A. If a member insurer is an insolvent insurer, the Association shall, in its discretion, either:
 - (1)(a) Guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, the policies or contracts of the insolvent insurer; or
 - (b) Assure payment of the contractual obligations of the insolvent insurer; and
 - (c) Provide such moneys, pledges, loans, notes, guarantees, or other means as are reasonably necessary to discharge such duties; or
- (2) Provide benefits and coverages in accordance with § 23-96-113.
- B. All proceedings in which the insolvent insurer is a party in any court in this state shall be stayed sixty (60) days from the date an order of liquidation, rehabilitation, or conservation is final to permit proper legal action by the Association on any matters germane to its powers or duties. As to judgment under any decision, order, verdict, or finding based on default, the Association may apply to have such judgment set aside by the same court that made such judgment and shall be permitted to defend against such suit on the merits.

23-96-113. Authority of association when proceeding under § 23-96-111 or § 23-96-112.

A.(1) When proceeding under § 23-96-111 or § 23-96-112(A)(2), the Association shall:

(a) With respect to life and accident and health insurance policies and annuities, assure payment of benefits for premiums identical to the premiums and benefits, except for terms of conversion and renewability, that would have been payable under the policies or contracts of the insolvent insurer, for claims incurred:

(i) With respect to group policies, and contracts, not later than the earlier of the next renewal date under such policies or contracts or forty-five (45) days, but in no event less than thirty (30) days, after the date on which the Association becomes obligated with respect to such policies and contracts;

(ii) With respect to nongroup policies, contracts and annuities, not later than the earlier of the next renewal date, if any, under such policies or contracts or one (1) year, but in no event less than thirty (30) days, from the date on which the Association becomes obligated with respect to such policies or contracts;

(b) Make diligent efforts to provide all known insureds or annuitants (for non-group policies and contracts) or group policy owners with respect to group policies and contracts thirty (30) days' notice of the termination (pursuant to Paragraph A(1) of this section) of the benefits provided;

(c) With respect to non-group life and accident and health insurance policies and annuities covered by the Association, make available to each known insured or annuitant, or owner if other than the insured or annuitant, and with respect to an individual formerly insured or formerly an annuitant under a group policy who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of Paragraph A(2)(a) of this section, if the insureds or annuitants had a right under law or the terminated policy or annuity to convert coverage to individual coverage or to continue an individual policy or annuity in force until a specified age or for a specified time, during which the insurer had no right unilaterally to make changes in any provisions of the policy or annuity or had a right only to make changes in premium by class.

(2)(a) In providing the substitute coverage required under Paragraph A(1)(c) of this section, the Association may offer either to reissue the terminated coverage or to issue an alternative policy.

(b) Alternative or reissued policies shall be offered without requiring evidence of insurability, and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy.

(c) The Association may reinsure any alternative or reissued policy;

(3)(a) Alternative policies adopted by the Association shall be subject to the approval of the domiciliary insurance commissioner and the receivership court. The Association may adopt alternative policies of various types for future issuance without regard to any particular impairment or insolvency.

(b) Alternative policies shall contain at least the minimum statutory provisions required in this state and provide benefits that shall not be unreasonable in relation to the premium charged. The Association shall set the premium in accordance with a table of rates which it shall adopt. The premium

shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but shall not reflect any changes in the health of the insured after the original policy was last underwritten.

(c) Any alternative policy issued by the Association shall provide coverage of a type similar to that of the policy issued by the impaired or insolvent insurer, as determined by the Association.

- B. When proceeding under § 23-96-111 or § 23-96-112(A) with respect to a policy or contract carrying guaranteed minimum interest rates, the Association shall assure the payment or crediting of a rate of interest consistent with § 23-96-106(A)(3).
- C. In carrying out its duties under §§ 23-96-111 and 23-96-112(A), the Association may:
- (1) Subject to approval by a court in this state, impose permanent policy or contract liens in connection with any guarantee, assumption, or reinsurance agreement, if the Association finds that the amounts which can be assessed under this chapter are less than the amounts needed to assure full and prompt performance of the Association's duties under this chapter or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of such permanent policy or contract liens to be in the public interest;
 - (2) Subject to approval by a court in this state, impose temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value. In addition, in the event of a temporary moratorium or moratorium charge imposed by the receivership court on payment of cash values or policy loans, or on any other right to withdraw funds held in conjunction with policies or contract, out of the assets of the impaired or insolvent insurer, the Association may defer the payment of cash values, policy loans or other rights by the Association for the period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the Association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.
 - (3) A deposit in this state, held pursuant to law or required by the commissioner for the benefit of creditors, including policy owners, not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of an insurer domiciled in this state or in a reciprocal state, pursuant to § 23-68-115, shall be promptly paid to the Association. The Association (i) shall be entitled to retain a portion of any amount so paid to it equal to the percentage determined by dividing the aggregate amount of policy owners claims related to that insolvency for which the Association has provided statutory benefits by the aggregate amount of all policy owners' claims in this state related to that insolvency and (ii) shall remit to the domiciliary receiver the amount so paid to the Association and retained pursuant to clause (i). Any amount so paid to the Association and retained by it pursuant to clause (i) shall be treated as a distribution of estate assets pursuant to § 23-68-126 or similar provision of the state of domicile of the impaired or insolvent insurer.
- D. In carrying out its duties in connection with guaranteeing, assuming or reinsuring policies or contracts under §§ 23-96-111 or 23-96-112(A), the association, subject to

approval of the receivership court, may issue substitute coverage for a policy or contract that provides an interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with the following provisions:

- (1) In lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for (i) a fixed rate or (ii) payments of dividends with minimum guarantees or (iii) a different method for calculating interest or changes in value;
- (2) There is no requirement for evidence of insurability, waiting period or other exclusion that would not have applied under the replaced policy or contract; and
- (3) The alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms.

23-96-114. Liability for benefits - Assignment or subrogation of rights.

- A. The benefits that the Association may become obligated to cover shall in no event exceed the lesser of:
- (1) The contractual obligations for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer; or
 - (2)(a) With respect to any one life, regardless of the number of policies or contracts:
 - (i) Three hundred thousand dollars (\$300,000) in life insurance death benefits or net cash surrender and net cash withdrawal values for life insurance;
 - (ii) Three hundred thousand dollars (\$300,000) in accident and health insurance benefits, including any net cash surrender and net cash withdrawal values;
 - (iii) Three hundred thousand dollars (\$300,000) in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;
 - (b) With respect to each individual participating in a governmental retirement benefit plan established under sections 401(k), 403(b), or 457, of the United States Internal Revenue Code covered by an unallocated annuity contract or the beneficiaries of each such individual if deceased, in the aggregate three hundred thousand dollars (\$300,000) in present value annuity benefits, including net cash surrender and net cash withdrawal values;
 - (c) With respect to any one (1) contract holder, one million dollars (\$1,000,000) in unallocated annuity contract benefits, irrespective of the number of contracts held by that contract holder.
- B.(1) Provided, however, that in no event shall the Association be liable to expend more than the three hundred thousand dollars (\$300,000) in the aggregate with respect to any one life under §§ 23-96-106, 23-96-107, and this section.
- (2) The limitations set forth in this subsection are limitations on the benefits for which the Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be

provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the Association's obligations under this chapter may be met by the use of assets attributable to covered policies or reimbursed to the Association pursuant to its subrogation and assignment rights.

- (3) In performing its obligations to provide coverage under § 23-96-111, the Association shall not be required to guarantee, assume, reinsure, or perform, or cause to be guaranteed, assumed, reinsured or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

C.(1) Any person receiving benefits under this chapter shall be deemed to have assigned the rights under, and any causes of action against any person for losses arising under, resulting from or otherwise relating to, the covered policy or contract to the Association to the extent of the benefits received because of this chapter, whether the benefits are payments of or on account of contractual obligations, continuation of coverage, or provision of substitute or alternative coverages. The Association may require an assignment to it of such rights and cause of action by any payee, policy, or contract owner, beneficiary, insured, or annuitant as a condition precedent to the receipt of any right or benefits conferred by this chapter upon such person.

- (2) The subrogation rights of the Association under this subsection shall have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this chapter.
- (3) In addition to Paragraphs C(1) and (2) above, the Association shall have all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary or payee of a policy or contract with respect to such policy or contracts.
- (4) If the preceding provisions of this subsection are invalid or ineffective with respect to any person or claim for any reason, the amount payable by the Association with respect to the related covered obligations shall be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies (or portion thereof) covered by the Association.
- (5) If the Association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the Association has rights as described in the preceding paragraphs of this subsection, the person shall pay to the Association the portion of the recovery attributable to the policies (or portion thereof) covered by the Association.

D.(1) For the purpose of carrying out its obligations under this chapter, the Association shall be deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the Association is entitled as subrogee pursuant to Subsection C of this section. Assets of the impaired or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this chapter.

- (2) "Assets attributable to covered policies", as used in this subsection, are that

proportion of the assets which the reserves that should have been established for such policies bear to the reserves that should have been established for all policies of insurance written by the impaired or insolvent insurer.

- E. As a creditor of the impaired or insolvent insurer as established in subsection D of this section and consistent with § 23-68-126, the Association and other similar associations shall be entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the assets become available, to reimburse it, as a credit against contractual obligations under this chapter. If the liquidator has not, within one hundred twenty (120) days of a final determination of insolvency of an insurer by the receivership court, made an application to the court for the approval of a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvency, then the Association shall be entitled to make application to the receivership court for approval of its own proposal to disburse these assets.
- F. It is the intent of the General Assembly that the coverage provided through the Arkansas Life and Health Insurance Guaranty Association for any annuity contract executed pursuant to § 11-9-210 shall be the lesser of the contractual obligations of the insurer or one hundred thousand dollars (\$100,000) in the present value of annuity benefits including net cash surrender and net cash withdrawal values as provided in subsection A of this section;
- G. It is the intent of the General Assembly that coverage provided by the Arkansas Life and Health Insurance Guaranty Association for annuity contracts executed pursuant to § 11-9-210, shall not be affected by the fact that the annuity payments are sent to the Workers' Compensation Commission for distribution to the claimants and beneficiaries, and that any funds provided by the Arkansas Life and Health Insurance Guaranty Association for payment to claimants or beneficiaries for whom annuity contracts are executed under § 11-9-210 shall be sent to the Workers' Compensation Commission for distribution to claimants or beneficiaries.

23-96-115. Assessments - Tax credits.

- A.(1) For the purpose of providing the funds necessary to carry out the powers and duties of the Association, the board of directors shall assess the member insurers, separately for each account, at such time and for such amounts as the board finds necessary.
 - (2) Assessments shall be due not less than thirty (30) days after prior written notice to the member insurers and shall accrue interest at ten percent (10%) per annum on and after the due date.
- B. There shall be two (2) classes of assessments, as follows:
 - (1) Class A assessments shall be authorized and called for the purpose of meeting administrative and legal costs and other expenses. Class A assessments may be authorized and called whether or not related to a particular impaired or insolvent insurer.
 - (2) Class B assessments shall be authorized and called to the extent necessary to carry out the powers and duties of the Association under §§ 23-96-106(B), 23-96-110 - 23-96-114, and 23-96-120 with regard to an impaired or an insolvent insurer.

C.(1)(a) The amount of a Class A assessment shall be determined by the board and may be authorized and called on a pro rata or non-pro rata basis. If pro rata, the board may provide that it be credited against future Class B assessments. The total of all non-pro rata assessments shall not exceed one hundred fifty dollars (\$150) per member insurer in any one (1) calendar year.

(b) The amount of a Class B assessment shall be allocated for assessment purposes among the accounts pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board in its sole discretion as being fair and reasonable under the circumstances.

- (2) Class B assessments against member insurers for each account shall be in the proportion that the premiums received on business in this state by each assessed member insurer or policies or contracts covered by each account for the three (3) most recent calendar years for which information is available preceding the year in which the insurer became insolvent (or in the case of an assessment with respect to an impaired insurer, the three (3) most recent calendar years for which information is available preceding the year in which the insurer became impaired) bears to such premiums received on business in this state for such calendar years by all assessed member insurers.
- (3) Assessments for funds to meet the requirements of the Association with respect to an impaired or insolvent insurer shall not be authorized or called until necessary to implement the purpose of this chapter.

D. Classification of assessments under Subsection B of this section and computation of assessments under Subsection C of this section shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The Association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within one hundred eighty (180) days after the assessment is authorized.

E. The Association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. Once the conditions that caused a deferral have been removed or rectified, the member insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the Association.

F.(1)(a) Subject to the provisions of Paragraph F(1)(b) of this section the total of all assessments authorized by the Association with respect to a member insurer for each subaccount of the life insurance and annuity account and for the accident and health account shall not in any one (1) calendar year exceed two percent (2%) of such insurer's average annual premiums received in this state on the policies and contracts covered by the subaccount or account during the three (3) calendar years preceding the year in which the insurer became an impaired or insolvent insurer.

(b) If two (2) or more assessments are authorized in one (1) calendar year with respect to insurers that become impaired or insolvent in different calendar years, the

average annual premiums for purposes of the aggregate assessment percentage limitation referenced in Paragraph (1)(a) of this subsection shall be equal and limited to the higher of the three-year average annual premiums for the applicable subaccount or account as calculated pursuant to this section.

(c) If the maximum assessment, together with the other assets of the Association in any account, does not provide in any one (1) year in either account an amount sufficient to carry out the responsibilities of the Association, the necessary additional funds shall be assessed as soon thereafter as permitted by this chapter.

(2) The board may provide in the plan of operation a method of allocating funds among claims, whether relating to one (1) or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

(3) If the maximum assessment for any subaccount of the life and annuity account in any one (1) year does not provide an amount sufficient to carry out the responsibilities of the Association, then pursuant to Paragraph C(2) of this section, the board shall assess the other subaccounts of the life and annuity account for the necessary additional amount, subject to the maximum stated in Paragraph F(1) of this section.

G. The board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each insurer to that account, the amount by which the assets of the account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the association with regard to that account, including assets accruing from assignment, subrogation, net realized gains, and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the Association and for future losses claims.

H. It shall be proper for any member insurer, in determining its premium rates and policyholder dividends as to any kind of insurance within the scope of this chapter, to consider the amount reasonably necessary to meet its assessment obligations under this chapter.

I.(1) The Association shall issue to each insurer paying an assessment under this chapter, other than Class A assessment, a certificate of contribution, in a form prescribed by the commissioner, for the amount of the assessment so paid.

(2) All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue.

(3) A certificate of contribution may be shown by the insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the commissioner may approve.

J.(1)(a) A member insurer may offset against its premium tax liability to this state an assessment described in Subsection I of this section to the extent of twenty percent (20%) of the amount of such assessment for each of the five (5) calendar years following the year in which such assessment was paid.

(b) In the event a member insurer should cease doing business, all uncredited assessments may be credited against its premium tax liability for the year it ceases doing business.

(2)(a) Any sums which are acquired by refund, pursuant to subsection G of this section, from the Association by member insurers and which have theretofore

been offset against premium taxes as provided in Paragraph J(1)(a) of this section, shall be paid by such insurers to this state in such manner as the tax authorities may require.

(b) The Association shall notify the commissioner that such refunds have been made.

23-96-116. Plan of operation.

A.(1) The Association shall submit to the commissioner a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the Association. The plan of operation and any amendments thereto shall become effective upon the commissioner's written approval or unless he has not disapproved it within thirty (30) days.

(2) If the Association fails to submit a suitable plan of operation within one hundred twenty (120) days following March 9, 1989, or if at any time thereafter the Association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this chapter. Such rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the Association and approved by the commissioner.

B. All member insurers shall comply with the plan of operation.

C. The plan of operation shall, in addition to requirements enumerated elsewhere in this chapter:

- (1) Establish procedures for handling the assets of the Association;
- (2) Establish the amount and method of reimbursing members of the board of directors under § 23-96-109B;
- (3) Establish regular places and times for meetings including telephone conference calls of the board of directors;
- (4) Establish procedures for records to be kept of all financial transactions of the Association, its agents, and the board of directors;
- (5) Establish the procedures whereby selections for the board of directors will be made and submitted to the commissioner;
- (6) Establish any additional procedures for assessments under § 23-96-115;
- (7) Contain additional provisions necessary or proper for the execution of the powers and duties of the Association.

D.(1) The plan of operation may provide that any or all powers and duties of the Association, except those under §§ 23-96-114C(3) and 23-96-115, may be delegated to the State Insurance Department or to a corporation, association, organization or other entity which performs or will perform functions similar to those of this association, or its equivalent, in two (2) or more states. Such a corporation, association, organization or other entity, including, as applicable, the State Insurance Department, shall be reimbursed for any payments made on behalf of the Association and shall be paid for its performance of any function of the Association.

(2) A delegation under this subsection shall take effect only with the approval of both the board of directors and the commissioner, and may be made only to a

corporation, association, organization or other entity, including the State Insurance Department, which extends protection not substantially less favorable and effective than that provided by this chapter.

23-96-117. Detection and prevention of insolvencies or impairments.

To aid in the detection and prevention of insurer insolvencies or impairments,

A. It shall be the duty of the commissioner:

- (1)(a) To notify the commissioners of all the other states, territories of the United States, and the District of Columbia when he takes any of the following actions against a member insurer:
 - (i) Revocation of license;
 - (ii) Suspension of license; or
 - (iii) Makes any formal order that such company restrict its premium writing, obtain additional contributions to surplus, withdraw from the state, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of policy owners or creditors.
- (b) Such notice shall be mailed to all commissioners within thirty (30) days following the action taken or the date on which such action occurs.
- (2)(a) To report to the board of directors when he has taken any of the actions set forth in Paragraph A(1) of this section or has received a report from any other commissioner indicating that any such action has been taken in another state.
- (b) Such report to the board of directors shall contain all significant details of the action taken or the report received from another commissioner.
- (3) To report to the board of directors when he has reasonable cause to believe from any examination, whether completed or in process, of any member insurer that such insurer may be an impaired or insolvent insurer.
- (4)(a) To furnish to the board of directors the National Association of Insurance Commissioners' Insurance Regulatory Information System (IRIS) ratios and listings of companies not included in the ratios developed by the National Association of Insurance Commissioners, and the board may use the information contained therein in carrying out its duties and responsibilities under this section.
- (b) Such report and the information contained therein shall be kept confidential by the board of directors until such time as made public by the commissioner or other lawful authority.

B. The commissioner may seek the advice and recommendations of the board of directors concerning any matter affecting his duties and responsibilities regarding the financial condition of member insurers and companies seeking admission to transact insurance business in this state.

C.(1) The board of directors may, upon majority vote, make reports and recommendations to the commissioner upon any matter germane to the solvency, liquidation, rehabilitation, or conservation of any member insurer or germane to the solvency of any company seeking to do an insurance business in this state.

(2) Such reports and recommendations shall not be considered public documents.

D. The board of directors may, upon majority vote, notify the commissioner of any information indicating any member insurer may be an impaired or insolvent insurer.

- E. The board of directors may, upon majority vote, make recommendations to the commissioner for the detection and prevention of insurer insolvencies.

23-96-118. Duties and powers of the commissioner.

In addition to the duties and powers enumerated elsewhere in this chapter,

A. The commissioner shall:

- (1) Upon request of the board of directors, provide the Association with a statement of the premiums in this and any other appropriate states for each member insurer;
- (2)(a) When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time.
 - (b) Notice to the impaired insurer shall constitute notice to its shareholders, if any.
 - (c) The failure of the insurer to promptly comply with such demand shall not excuse the Association from the performance of its powers and duties under this chapter;
- (3) In any liquidation or rehabilitation proceeding involving a domestic insurer, be appointed as the liquidator or rehabilitator.

B.(1) The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation.

- (2) As an alternative, the commissioner may levy a forfeiture on any member insurer which fails to pay an assessment when due. Such forfeiture shall not exceed five percent (5%) of the unpaid assessment per month, but no forfeiture shall be less than one hundred dollars (\$100) per month.

C. A final action of the board of directors or the Association may be appealed to the commissioner by any member insurer if such appeal is taken within sixty (60) days of its receipt of notice of the final action being appealed. If a member company is appealing an assessment, the amount assessed shall be paid to the Association and available to meet Association obligations during the pendency of an appeal. If the appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member insurer. Any final action or order of the commissioner shall be subject to judicial review in a court of competent jurisdiction in accordance with the laws of this state that apply to actions or orders of the commissioner.

D. If the Association fails to act within a reasonable period of time as provided in §§ 23-96-112A, 23-96-113, and 23-96-120, the commissioner shall have the powers and duties of the Association under this chapter with respect to impaired or insolvent insurers.

23-96-119. Distributions of ownership rights.

A.(1) Prior to the termination of any liquidation, rehabilitation, or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the Association, the shareholders, and policy owners of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution

of the ownership rights of such insolvent insurer. In such determination, consideration shall be given to the welfare of the policy owners of the continuing or successor insurer.

- (2) No distribution to stockholders, if any, of an impaired or insolvent insurer shall be made until and unless the total amount of valid claims of the Association with interest thereon for funds expended in carrying out its powers and duties under §§ 23-96-111 - 23-96-114, and 23-96-120 with respect to such insurer have been fully recovered by the Association.

B.(1) If an order for liquidation or rehabilitation of an insurer domiciled in this state has been entered, the receiver appointed under such order shall have a right to recover on behalf of the insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the insurer on its capital stock, made at any time during the five (5) years preceding the petition for liquidation or rehabilitation subject to the limitations of Paragraphs B(2), (3), and (4) of this section.

- (2) No such distribution shall be recoverable if the insurer shows that, when paid, the distribution was lawful and reasonable and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.
- (3)(a) Any person who was an affiliate that controlled the insurer at the time the distributions were paid shall be liable up to the amount of distributions he received.

(b) Any person who was an affiliate that controlled the insurer at the time the distributions were declared, shall be liable up to the amount of distributions he would have received if they had been paid immediately.

(c) If two (2) or more persons are liable with respect to the same distributions, they shall be jointly and severally liable.

- (4) The maximum amount recoverable under this subsection shall be the amount needed in excess of all other available assets of the insolvent insurer to pay the contractual obligations of the insolvent insurer.
- (5) If any person liable under Paragraph B(3) of this section is insolvent, all its affiliates that controlled it at the time the distribution was paid, shall be jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

23-96-120. Payment of premiums.

- A. Nonpayment of premiums within thirty-one (31) days after the date required under the terms of any guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage shall terminate the Association's obligations under such policy or coverage under this chapter with respect to such policy or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of the chapter.
- B. Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the Association, and the Association shall be liable for unearned premiums due to policy or contract owners arising after the entry of such order.

23-96-121. Reissuance of terminated coverage.

- A. If the Association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy, the premium shall be set by the Association in accordance with the amount of insurance provided and the age and class of risk, subject to approval of the domiciliary commissioner and the receivership court.
- B. The Association's obligations with respect to coverage under any policy of the impaired or insolvent insurer or under any reissued or alternative policy shall cease on the date such coverage or policy is replaced by another similar policy by the policy owner, the insured, or the Association.