CHAPTER 72A

REGULATION OF TRADE PRACTICES

72A.125 RENTAL VEHICLE PERSONAL ACCIDENT INSURANCE; SPECIAL REQUIREMENTS.

Subdivision 1. **Definition.** (a) "Auto rental company" means a corporation, partnership, individual, or other person that is engaged primarily in the renting of motor vehicles at per diem rates.

(b) "Rental vehicle personal accident insurance" means accident only insurance providing accidental death benefits, dismemberment benefits and/or reimbursement for medical expenses which is issued by an insurer authorized in this state to issue accident and health insurance. These coverages are nonqualified plans under chapter 62E.

Subd. 2. **Sale by auto rental companies.** An auto rental company that offers or sells rental vehicle personal accident insurance in this state in conjunction with the rental of a vehicle shall only sell these products if the forms and rates have met the relevant requirements of section 62A.02, taking into account the possible infrequency and severity of loss that may be incurred. Sections 60A.17 and 60A.1701 do not apply if the persons engaged in the sale of these products are employees of the auto rental company who do not receive commissions or other remuneration for selling the product in addition to their regular compensation. Compensation may not be determined in any part by the sale of insurance products. The auto rental company before engaging in the sale of the product must file with the commissioner the following documents:

(1) an appointment of the commissioner as agent for service of process;

(2) an agreement that the auto rental company assumes all responsibility for the authorized actions of all unlicensed employees who sell the insurance product on its behalf in conjunction with the rental of its vehicles;

(3) an agreement that the auto rental company with respect to itself and its employees will be subject to this chapter regarding the marketing of the insurance products and the conduct of those persons involved in the sale of insurance products in the same manner as if it were a licensed agent.

An auto rental company failing to file the documents in clauses (1) to (3) is guilty of an individual violation as to the unlicensed sale of insurance for each sale that occurs after June 2, 1987, until they make the required filings. Each individual sale after June 2, 1987, and prior to the filing required by this section is subject to, in addition to any other penalties allowable by law, up to a $100 per violation fine. Further, the sale of the insurance product by an auto rental company or any employee or agent of the company after June 2, 1987, without having complied with this section shall be deemed to be in acceptance of the provisions of this section.

Insurance sold pursuant to this subdivision must be limited in availability to rental vehicle customers though coverage may extend to the customer, other drivers, and passengers using or riding in the rented vehicles; and limited in duration to a period equal to and concurrent with that of the vehicle rental.

Persons purchasing rental vehicle personal accident insurance may be provided a certificate summarizing the policy provisions in lieu of a copy of the policy if a copy

of the policy is available for inspection at the place of sale and a free copy of the policy may be obtained from the auto rental company's home office.

The commissioner may, after a hearing, revoke an auto rental company's right to operate under this section if the company has repeatedly violated the insurance laws of this state and the revocation is in the public interest.

History: *1987 c 337 s 115*

72A.20 METHODS, ACTS AND PRACTICES WHICH ARE DEFINED AS UNFAIR OR DECEPTIVE.

[For text of subds 1 to 10, see M.S.1986]

Subd. 11. **Application to certain sections.** Violating any provision of the following sections of this chapter not set forth in this section shall constitute an unfair method of competition and an unfair and deceptive act or practice: sections 72A.12, subdivisions 2, 3, and 4, 72A.16, subdivision 2, 72A.03 and 72A.04, 72A.08, subdivision 1, as modified by section 72A.08, subdivision 4, 72A.201, and 65B.13.

[For text of subd 12, see M.S.1986]

Subd. 12a. [Renumbered as 72A.201]

[For text of subds 13 and 14, see M.S.1986]

Subd. 15. **Practices not held to be discrimination or rebates.** Nothing in subdivision 8, 9, or 10, or in section 72A.12, subdivisions 3 and 4, shall be construed as including within the definition of discrimination or rebates any of the following practices:

(1) in the case of any contract of life insurance or annuity, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided that any bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders;

(2) in the case of life insurance policies issued on the industrial debit plan, making allowance, to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer, in an amount which fairly represents the saving in collection expense;

(3) readjustment of the rate of premium for a group insurance policy based on the loss or expense experienced thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year;

(4) in the case of an individual or group health insurance policy, the payment of differing amounts of reimbursement to insureds who elect to receive health care goods or services from providers designated by the insurer, provided that each insurer shall on or before August 1 of each year file with the commissioner summary data regarding the financial reimbursement offered to providers so designated.

Any insurer which proposes to offer an arrangement authorized under this clause shall disclose prior to its initial offering and on or before August 1 of each year thereafter as a supplement to its annual statement submitted to the commissioner pursuant to section 60A.13, subdivision 1, the following information:

(a) the name which the arrangement intends to use and its business address;

(b) the name, address, and nature of any separate organization which administers the arrangement on the behalf of the insurers; and

(c) the names and addresses of all providers designated by the insurer under this clause and the terms of the agreements with designated health care providers.

The commissioner shall maintain a record of arrangements proposed under this clause, including a record of any complaints submitted relative to the arrangements.

[For text of subd 16, see M.S.1986]

Subd. 17. **Return of premiums.** (a) Refusing, upon surrender of an individual policy of life insurance, to refund to the estate of the insured all unearned premiums paid on the policy covering the insured as of the time of the insured's death if the unearned premium is for a period of more than one month.

The insurer may deduct from the premium any previously accrued claim for loss or damage under the policy.

For the purposes of this section, a premium is unearned during the period of time the insurer has not been exposed to any risk of loss.

(b) Refusing, upon termination or cancellation of a policy of automobile insurance under section 65B.14, subdivision 2, or a policy of homeowner's insurance under section 65A.27, subdivision 4, or a policy of accident and sickness insurance under section 62A.01, or a policy of comprehensive health insurance under chapter 62E, to refund to the insured all unearned premiums paid on the policy covering the insured as of the time of the termination or cancellation if the unearned premium is for a period of more than one month.

The insurer may deduct from the premium any previously accrued claim for loss or damage under the policy.

For purposes of this section, a premium is unearned during the period of time the insurer has not been exposed to any risk of loss.

Subd. 18. **Improper business practices.** (a) Improperly withholding, misappropriating, or converting any money belonging to a policyholder, beneficiary, or other person when received in the course of the insurance business; or (b) engaging in fraudulent, coercive, or dishonest practices in connection with the insurance business, shall constitute an unfair method of competition and an unfair and deceptive act or practice.

Subd. 19. **Support for underwriting standards.** No life or health insurance company doing business in this state shall engage in any selection or underwriting process unless the insurance company establishes beforehand substantial data, actuarial projections, or claims experience which support the underwriting standards used by the insurance company. The data, projections, or claims experience used to support the selection or underwriting process is not limited to only that of the company. The experience, projections, or data of other companies or a rate service organization may be used as well.

History: *1987 c 113 s 1; 1987 c 337 s 116-119*

72A.201 REGULATION OF CLAIMS PRACTICES.

Subdivision 1. **Administrative enforcement.** The commissioner may, in accordance with chapter 14, adopt rules to ensure the prompt, fair, and honest processing of claims and complaints. The commissioner may, in accordance with sections 72A.22 to 72A.25, seek and impose appropriate administrative remedies, including fines, for (1) a violation of this section or the rules adopted pursuant to this section; or (2) a violation of section 72A.20, subdivision 12. The commissioner need not show a general business practice in taking an administrative action for these violations.

No individual violation constitutes an unfair, discriminatory, or unlawful practice in business, commerce, or trade for purposes of section 8.31.

Subd. 2. **Construction.** The policy of the department of commerce, in interpreting and enforcing this section, will be to take into consideration all pertinent facts and circumstances in determining the severity and appropriateness of the action to be taken in regard to any violation of this section.

The magnitude of the harm to the claimant or insured, and any actions by the insured, claimant, or insurer that mitigate or exacerbate the impact of the violation may be considered.

Actions of the claimant or insured which impeded the insurer in processing or

settling the claim, and actions of the insurer which increased the detriment to the claimant or insured may also be considered in determining the appropriate administrative action to be taken.

Subd. 3. **Definitions.** For the purposes of this section, the following terms have the meanings given them.

(1) Adjuster or adjusters. "Adjuster" or "adjusters" is as defined in section 72B.02.

(2) Agent. "Agent" means insurance agents or insurance agencies licensed pursuant to section 60A.17, and representatives of these agents or agencies.

(3) Claim. "Claim" means a request or demand made with an insurer for the payment of funds or the provision of services under the terms of any policy, certificate, contract of insurance, binder, or other contracts of temporary insurance. The term does not include a claim under a health insurance policy made by a participating provider with an insurer in accordance with the participating provider's service agreement with the insurer which has been filed with the commissioner of commerce prior to its use.

(4) Claim settlement. "Claim settlement" means all activities of an insurer related directly or indirectly to the determination of the extent of liabilities due or potentially due under coverages afforded by the policy, and which result in claim payment, claim acceptance, compromise, or other disposition.

(5) Claimant. "Claimant" means any individual, corporation, association, partnership, or other legal entity asserting a claim against any individual, corporation, association, partnership, or other legal entity which is insured under an insurance policy or insurance contract of an insurer.

(6) Complaint. "Complaint" means a communication primarily expressing a grievance.

(7) Insurance policy. "Insurance policy" means any evidence of coverage issued by an insurer including all policies, contracts, certificates, riders, binders, and endorsements which provide or describe coverage. The term includes any contract issuing coverage under a self-insurance plan, group self-insurance plan, or joint self-insurance employee health plans.

(8) Insured. "Insured" means an individual, corporation, association, partnership, or other legal entity asserting a right to payment under their insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by the policy or contract. The term does not apply to a person who acquires rights under a mortgage.

(9) Insurer. "Insurer" includes any individual, corporation, association, partnership, reciprocal exchange, Lloyds, fraternal benefits society, self-insurer, surplus line insurer, self-insurance administrator, and nonprofit service plans under the jurisdiction of the department of commerce.

(10) Investigation. "Investigation" means a reasonable procedure adopted by an insurer to determine whether to accept or reject a claim.

(11) Notification of claim. "Notification of claim" means any communication to an insurer by a claimant or an insured which reasonably apprises the insurer of a claim brought under an insurance contract or policy issued by the insurer. Notification of claim to an agent of the insurer is notice to the insurer.

(12) Proof of loss. "Proof of loss" means the necessary documentation required from the insured to establish entitlement to payment under a policy.

(13) Self-insurance administrator. "Self-insurance administrator" means any vendor of risk management services or entities administering self-insurance plans, licensed pursuant to section 60A.23, subdivision 8.

(14) Self-insured or self-insurer. "Self-insured" or "self-insurer" means any entity authorized pursuant to section 65B.48, subdivision 3; chapter 62H; section 176.181, subdivision 2; Laws of Minnesota 1983, chapter 290, section 171; section 471.617; or section 471.981 and includes any entity which, for a fee, employs the services of vendors of risk management services in the administration of a self-insurance plan as defined by section 60A.23, subdivision 8, clause (2), subclauses (a) and (d).

Subd.4. **Standards for claim filing and handling.** The following acts by an insurer, an adjuster, a self-insured, or a self-insurance administrator constitute unfair settlement practices:

(1) except for claims made under a health insurance policy, after receiving notification of claim from an insured or a claimant, failing to acknowledge receipt of the notification of the claim within ten business days, and failing to promptly provide all necessary claim forms and instructions to process the claim, unless the claim is settled within ten business days. The acknowledgment must include the telephone number of the company representative who can assist the insured or the claimant in providing information and assistance that is reasonable so that the insured or claimant can comply with the policy conditions and the insurer's reasonable requirements. If an acknowledgment is made by means other than writing, an appropriate notation of the acknowledgment must be made in the claim file of the insurer and dated. An appropriate notation must include at least the following information where the acknowledgment is by telephone or oral contact:

(i) the telephone number called, if any;

(ii) the name of the person making the telephone call or oral contact;

(iii) the name of the person who actually received the telephone call or oral contact;

(iv) the time of the telephone call or oral contact; and

(v) the date of the telephone call or oral contact;

(2) failing to reply, within ten business days of receipt, to all other communications about a claim from an insured or a claimant that reasonably indicate a response is requested or needed;

(3) unless provided otherwise by law or in the policy, failing to complete its investigation and inform the insured or claimant of acceptance or denial of a claim within 30 business days after receipt of notification of claim unless the investigation cannot be reasonably completed within that time. In the event that the investigation cannot reasonably be completed within that time, the insurer shall notify the insured or claimant within the time period of the reasons why the investigation is not complete and the expected date the investigation will be complete. For claims made under a health policy the notification of claim must be in writing;

(4) where evidence of suspected fraud is present, the requirement to disclose their reasons for failure to complete the investigation within the time period set forth in clause (3) need not be specific. The insurer must make this evidence available to the department of commerce if requested;

(5) failing to notify an insured who has made a notification of claim of all available benefits or coverages which the insured may be eligible to receive under the terms of a policy and of the documentation which the insured must supply in order to ascertain eligibility;

(6) unless otherwise provided by law or in the policy, requiring an insured to give written notice of loss or proof of loss within a specified time, and thereafter seeking to relieve the insurer of its obligations if the time limit is not complied with, unless the failure to comply with the time limit prejudices the insurer's rights and then only if the insurer gave prior notice to the insured of the potential prejudice;

(7) advising an insured or a claimant not to obtain the services of an attorney or an adjuster, or representing that payment will be delayed if an attorney or an adjuster is retained by the insured or the claimant;

(8) failing to advise in writing an insured or claimant who has filed a notification of claim known to be unresolved, and who has not retained an attorney, of the expiration of a statute of limitations at least 60 days prior to that expiration. For the purposes of this clause, any claim on which the insurer has received no communication from the insured or claimant for a period of two years preceding the expiration of the applicable statute of limitations shall not be considered to be known to be unresolved and notice need not be sent pursuant to this clause;

(9) demanding information which would not affect the settlement of the claim;

(10) unless expressly permitted by law or the policy, refusing to settle a claim of an insured on the basis that the responsibility should be assumed by others;

(11) failing, within 60 business days after receipt of a properly executed proof of loss, to advise the insured of the acceptance or denial of the claim by the insurer. No insurer shall deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to the provision, condition, or exclusion is included in the denial. The denial must be given to the insured in writing with a copy filed in the claim file;

(12) denying or reducing a claim on the basis of an application which was altered or falsified by the agent or insurer without the knowledge of the insured;

(13) failing to notify the insured of the existence of the additional living expense coverage when an insured under a homeowners policy sustains a loss by reason of a covered occurrence and the damage to the dwelling is such that it is not habitable;

(14) failing to inform an insured or a claimant that the insurer will pay for an estimate of repair if the insurer requested the estimate and the insured or claimant had previously submitted two estimates of repair.

Subd. 5. **Standards for fair settlement offers and agreements.** The following acts by an insurer, an adjuster, a self-insured, or a self-insurance administrator constitute unfair settlement practices:

(1) making any partial or final payment, settlement, or offer of settlement, which does not include an explanation of what the payment, settlement, or offer of settlement is for;

(2) making an offer to an insured of partial or total settlement of one part of a claim contingent upon agreement to settle another part of the claim;

(3) refusing to pay one or more elements of a claim by an insured for which there is no good faith dispute;

(4) threatening cancellation, rescission, or nonrenewal of a policy as an inducement to settlement of a claim;

(5) failing to issue payment for any amount finally agreed upon in settlement of all or part of any claim within five business days from the receipt of the agreement by the insurer or from the date of the performance by the claimant of any conditions set by such agreement, whichever is later;

(6) failing to inform the insured of the policy provision or provisions under which payment is made;

(7) settling or attempting to settle a claim or part of a claim with an insured under actual cash value provisions for less than the value of the property immediately preceding the loss, including all applicable taxes and license fees. In no case may an insurer be required to pay an amount greater than the amount of insurance;

(8) except where limited by policy provisions, settling or offering to settle a claim or part of a claim with an insured under replacement value provisions for less than the sum necessary to replace the damaged item with one of like kind and quality, including all applicable taxes, license, and transfer fees;

(9) reducing or attempting to reduce for depreciation any settlement or any offer of settlement for items not adversely affected by age, use, or obsolescence;

(10) reducing or attempting to reduce for betterment any settlement or any offer of settlement unless the resale value of the item has increased over the preloss value by the repair of the damage.

Subd. 6. **Standards for automobile insurance claims handling, settlement offers, and agreements.** In addition to the acts specified in subdivisions 4, 5, 7, 8, and 9, the following acts by an insurer, adjuster, or a self-insured or self-insurance administrator constitute unfair settlement practices:

(1) if an automobile insurance policy provides for the adjustment and settlement of an automobile total loss on the basis of actual cash value or replacement with like

kind and quality and the insured is not an automobile dealer, failing to offer one of the following methods of settlement:

(a) comparable and available replacement automobile, with all applicable taxes, license fees, at least pro rata for the unexpired term of the replaced automobile's license, and other fees incident to the transfer or evidence of ownership of the automobile paid, at no cost to the insured other than the deductible amount as provided in the policy;

(b) a cash settlement based upon the actual cost of purchase of a comparable automobile, including all applicable taxes, license fees, at least pro rata for the unexpired term of the replaced automobile's license, and other fees incident to transfer of evidence of ownership, less the deductible amount as provided in the policy. The costs must be determined by:

(i) the cost of a comparable automobile, adjusted for mileage, condition, and options, in the local market area of the insured, if such an automobile is available in that area; or

(ii) one of two or more quotations obtained from two or more qualified sources located within the local market area when a comparable automobile is not available in the local market area. The insured shall be provided the information contained in all quotations prior to settlement; or

(iii) any settlement or offer of settlement which deviates from the procedure above must be documented and justified in detail. The basis for the settlement or offer of settlement must be explained to the insured;

(2) if an automobile insurance policy provides for the adjustment and settlement of an automobile partial loss on the basis of repair or replacement with like kind and quality and the insured is not an automobile dealer, failing to offer one of the following methods of settlement:

(a) to assume all costs, including reasonable towing costs, for the satisfactory repair of the motor vehicle. Satisfactory repair includes repair of both obvious and hidden damage as caused by the claim incident. This assumption of cost may be reduced by applicable policy provision; or

(b) to offer a cash settlement sufficient to pay for satisfactory repair of the vehicle. Satisfactory repair includes repair of obvious and hidden damage caused by the claim incident, and includes reasonable towing costs;

(3) regardless of whether the loss was total or partial, in the event that a damaged vehicle of an insured cannot be safely driven, failing to exercise the right to inspect automobile damage prior to repair within five business days following receipt of notification of claim. In other cases the inspection must be made in 15 days;

(4) regardless of whether the loss was total or partial, requiring unreasonable travel of a claimant or insured to inspect a replacement automobile, to obtain a repair estimate, to allow an insurer to inspect a repair estimate, to allow an insurer to inspect repairs made pursuant to policy requirements, or to have the automobile repaired;

(5) regardless of whether the loss was total or partial, if loss of use coverage exists under the insurance policy, failing to notify an insured at the time of the insurer's acknowledgment of claim, or sooner if inquiry is made, of the fact of the coverage, including the policy terms and conditions affecting the coverage and the manner in which the insured can apply for this coverage;

(6) regardless of whether the loss was total or partial, failing to include the insured's deductible in the insurer's demands under its subrogation rights. Subrogation recovery must be shared at least on a proportionate basis with the insured, unless the deductible amount has been otherwise recovered by the insured. No deduction for expenses may be made from the deductible recovery unless an attorney is retained to collect the recovery, in which case deduction may be made only for a pro rata share of the cost of retaining the attorney;

(7) requiring as a condition of payment of a claim that repairs to any damaged vehicle must be made by a particular contractor or repair shop or that parts, other than window glass, must be replaced with parts other than original equipment parts;

(8) where liability is reasonably clear, failing to inform the claimant in an automobile property damage liability claim that the claimant may have a claim for loss of use of the vehicle;

(9) failing to make a good faith assignment of comparative negligence percentages in ascertaining the issue of liability;

(10) failing to pay any interest required by statute on overdue payment for an automobile personal injury protection claim;

(11) if an automobile insurance policy contains either or both of the time limitation provisions as permitted by section 65B.55, subdivisions 1 and 2, failing to notify the insured in writing of those limitations at least 60 days prior to the expiration of that time limitation;

(12) if an insurer chooses to have an insured examined as permitted by section 65B.56, subdivision 1, failing to notify the insured of all of the insured's rights and obligations under that statute, including the right to request, in writing, and to receive a copy of the report of the examination.

Subd. 7. **Standards for releases.** The following acts by an insurer, adjuster, or self-insured or self-insurance administrator constitute unfair settlement practices:

(1) requesting or requiring an insured or a claimant to sign a release that extends beyond the subject matter that gave rise to the claim payment;

(2) issuing a check or draft in payment of a claim that contains any language or provision that implies or states that acceptance of the check or draft constitutes a final settlement or release of any or all future obligations arising out of the loss.

Subd. 8. **Standards for claim denial.** The following acts by an insurer, adjuster, or self-insured, or self-insurance administrator constitute unfair settlement practices:

(1) denying a claim or any element of a claim on the grounds of a specific policy provision, condition, or exclusion, without informing the insured of the policy provision, condition, or exclusion on which the denial is based;

(2) denying a claim without having made a reasonable investigation of the claim;

(3) denying a liability claim because the insured has requested that the claim be denied;

(4) denying a liability claim because the insured has failed or refused to report the claim, unless an independent evaluation of available information indicates there is no liability;

(5) denying a claim without including the following information:

(i) the basis for the denial;

(ii) the name, address, and telephone number of the insurer's claim service office or the claim representative of the insurer to whom the insured or claimant may take any questions or complaints about the denial; and

(iii) the claim number and the policy number of the insured;

(6) denying a claim because the insured or claimant failed to exhibit the damaged property unless:

(i) the insurer, within a reasonable time period, made a written demand upon the insured or claimant to exhibit the property; and

(ii) the demand was reasonable under the circumstances in which it was made.

Subd. 9. **Standards for communications with the department.** In addition to the acts specified elsewhere in this section and section 72A.20, the following acts by an insurer, adjuster, or a self-insured or self-insurance administrator constitute unfair settlement practices:

(1) failure to respond, within 15 working days after receipt of an inquiry from the commissioner, about a claim, to the commissioner;

(2) failure, upon request by the commissioner, to make specific claim files available to the commissioner;

(3) failure to include in the claim file all written communications and transactions

emanating from, or received by, the insurer, as well as all notes and work papers relating to the claim. All written communications and notes referring to verbal communications must be dated by the insurer;

(4) failure to submit to the commissioner, when requested, any summary of complaint data reasonably required;

(5) failure to compile and maintain a file on all complaints. If the complaint deals with a loss, the file must contain adequate information so as to permit easy retrieval of the entire file. If the complaint alleges that the company, or agent of the company, or any agent producing business written by the company is engaged in any unfair, false, misleading, dishonest, fraudulent, untrustworthy, coercive, or financially irresponsible practice, or has violated any insurance law or rule, the file must indicate what investigation or action was taken by the company. The complaint file must be maintained for at least four years after the date of the complaint.

Subd. 10. **Scope.** This section does not apply to workers' compensation insurance. Nothing in this section abrogates any policy provisions.

History: *1984 c 555 s 3; 1987 c 64 s 1*

72A.23 [Repealed, 1987 c 336 s 47]

72A.24 [Repealed, 1987 c 336 s 47]

72A.27 APPEAL.

Any decree or order of a district court made and entered under section 72A.25 is subject to review by appeal as in other civil cases. The appeal must be taken within the time prescribed by law for taking appeals from orders of the district courts.

History: *1987 c 336 s 8*

72A.28 [Repealed, 1987 c 336 s 47]

72A.31 CERTAIN ACTS DEEMED UNFAIR METHOD OF COMPETITION.

Subdivision 1. No person, firm or corporation engaged in the business of financing the purchase of real or personal property or of lending money on the security of real or personal property or who acts as agent or broker for one who purchases real property and borrows money on the security thereof, and no trustee, director, officer, agent or other employee of any such person, firm, or corporation shall directly or indirectly:

(1) require, as a condition precedent to such purchase or financing the purchase of such property or to loaning money upon the security of a mortgage thereon, or as a condition prerequisite for the renewal or extension of any such loan or mortgage or for the performance of any other act in connection therewith, that the person, firm or corporation making such purchase or for whom such purchase is to be financed or to whom the money is to be loaned or for whom such extension, renewal or other act is to be granted or performed negotiate any policy of insurance or renewal thereof covering such property through a particular agent, or insurer, or

(2) refuse to accept any policy of insurance covering such property because it was not negotiated through or with any particular agent, or insurer, or

(3) refuse to accept any policy of insurance covering the property issued by an insurer that is a member insurer as defined by section 60C.03, subdivision 6, or

(4) require any policy of insurance covering the property to exceed the replacement cost of the buildings on the mortgaged premises.

This section shall not prevent the disapproval of the insurer or a policy of insurance by any such person, firm, corporation, trustee, director, officer, agent or employee where there are reasonable grounds for believing that the insurer is insolvent or that such insurance is unsatisfactory as to placement with an unauthorized insurer, adequacy of the coverage, adequacy of the insurer to assume the risk to be insured, the assessment features to which the policy is subject, or other grounds which are based on

the nature of the coverage and which are not arbitrary, unreasonable or discriminatory, nor shall this section prevent a mortgage lender or mortgage servicer from requiring that a policy of insurance or renewal thereof be in conformance with standards of the federal national mortgage association or the federal home loan mortgage corporation, nor shall this section forbid the securing of insurance or a renewal thereof at the request of the borrower or because of the borrower's failure to furnish the necessary insurance or renewal thereof. For purposes of this section, "insurer" includes a township mutual fire insurance company operating under sections 67A.01 to 67A.26 and a farmers mutual fire insurance company operating under sections 67A.27 to 67A.39.

Upon notice of any such disapproval of or refusal to accept an insurer or a policy of insurance, the commissioner may order the approval of the insurer or the acceptance of the tendered policy of insurance, or both, if the commissioner determines such disapproval or refusal to accept is not in accordance with the foregoing requirements. Failure to comply with such an order of the commissioner of commerce shall be deemed a violation of this section.

[For text of subd 2, see M.S.1986]

History: *1987 c 337 s 120*

72A.325 INSURANCE FOR FUNERAL OR BURIAL EXPENSE; FREEDOM OF CHOICE.

No insurance company, agent, or other person engaged in the business of providing insurance or other benefits for the payment of any funeral or burial expense, shall designate, endorse, or otherwise promote any particular mortician, funeral director, funeral establishment, cemetery, or any other party offering funeral or burial services or supplies, as the beneficiary or recipient of the benefits, so as to deprive the family, next of kin, or other representative of the deceased policyholder of the right to select the funeral or burial services and supplies of their choice. No owner, director, or employee of a funeral establishment, or entity having a direct equity interest in a funeral establishment, shall receive any fee, commission, or other reimbursement on any insurance sale facilitated through the funeral establishment.

No owner, director, or employee of a funeral establishment shall receive any fee for endorsing insurance policies, plans, or services.

History: *1987 c 233 s 1*

72A.41 TRANSACTING BUSINESS WITHOUT CERTIFICATE OF AUTHORITY PROHIBITED.

Subdivision 1. It is unlawful for any company to enter into a contract of insurance as an insurer or to transact insurance business in this state, as set forth in subdivision 2, without a certificate of authority from the commissioner; provided that this subdivision does not apply to: (a) contracts of insurance procured by agents under the authority of sections 60A.195 to 60A.209; (b) contracts of reinsurance and contracts of ocean or wet marine and transportation insurance; (c) transactions in this state involving a policy lawfully solicited, written and delivered outside of this state covering only subjects of insurance not resident, located, or expressly to be performed in this state at the time of issuance and which transactions are subsequent to the issuance of the policy; (d) transactions in this state involving group or blanket insurance and group annuities where the master policy of such groups was lawfully issued and delivered in a state in which the company was authorized to do an insurance business where, except for group annuities, the insurer complies with section 72A.13. The commissioner may require the insurer which has issued such master policy to submit any information as the commissioner reasonably requires in order to determine if probable cause exists to convene a hearing to determine whether the total charges for the insurance to the persons insured are unreasonable in relation to the benefits provided under the policy; (e) transactions in this state involving a policy of insurance or annuity issued prior to July 1, 1967; or (f) contract of insurance procured under the authority of section

60A.19, subdivision 8; or (g) transactions in this state involving contracts of insurance covering property or risks not located in this state.

[For text of subds 2 and 3, see M.S.1986]

History: *1987 c 384 art 2 s 15*