CHAPTER 72A

REGULATION OF TRADE PRACTICES

72A.001 APPLICATION OF LAWS 2005, CHAPTER 56, TERMINOLOGY CHANGES.

State agencies shall use the terminology changes specified in Laws 2005, chapter 56, section 1, when printed material and signage are replaced and new printed material and signage are obtained. State agencies do not have to replace existing printed material and signage

to comply with Laws 2005, chapter 56, sections 1 and 2. Language changes made according to Laws 2005, chapter 56, sections 1 and 2, shall not expand or exclude eligibility to services.

History: *2005 c 56 s 3*

SCOPE

72A.01 SCOPE.

This chapter includes certain prohibitions and penalties. Other prohibitions and penalties may be found in other articles of Laws 1967, chapter 395, and other state laws.

History: *1967 c 395 art 12 s 1*

PROHIBITIONS AND PENALTIES IN GENERAL

72A.02 VIOLATIONS AS TO POLICIES OF INSURANCE.

Every company, and every officer and agent of any company, making, issuing, delivering, or tendering any policy of insurance of any kind, or directing any of the same to be done, in willful violation of any of the provisions of law, for a first offense, shall be guilty of a misdemeanor, and for each subsequent offense, of a gross misdemeanor; and, in addition to all other penalties prescribed by law, every company issuing any such policy shall be disqualified from doing any insurance business in this state until the payment of all fines imposed and for one year thereafter.

History: *1967 c 395 art 12 s 2*

72A.03 AGENT OF INSURER; PROCURING PREMIUMS BY FRAUD.

Every insurance agent who acts for another in negotiating a contract of insurance by an insurance company shall be held to be the company's agent for the purpose of collecting or securing the premiums therefor, whatever conditions or stipulations may be contained in the contract or policy. Any such agent who by fraudulent representations procures payment, or an obligation for the payment, of an insurance premium shall be guilty, for the first offense, of a misdemeanor, and for each subsequent offense, of a gross misdemeanor.

History: *1967 c 395 art 12 s 3; 1986 c 444*

72A.04 FALSE STATEMENTS IN APPLICATION.

Every solicitor, agent, examining physician, or other person who knowingly or willfully makes a false or fraudulent statement in, or relative to, any application for insurance or membership for any purpose shall be guilty of a gross misdemeanor.

History: *1967 c 395 art 12 s 4*

72A.05 FAILURE TO MAKE REPORT OR COMPLY WITH LAW.

Every officer and agent of any insurance company required to make any report or perform any act who shall neglect or refuse to comply with such requirement, and every agent, solicitor, or collector of the corporation in this state who fails or neglects to procure from the commissioner a certificate of authority to do such business, or who fails or refuses to comply with, or violates, any provision of the insurance law, shall be guilty, for the first offense, of a misdemeanor, and for each subsequent offense, of a gross misdemeanor.

History: *1967 c 395 art 12 s 5*

72A.06 [Repealed, 1977 c 316 s 3]

72A.061 MANDATORY FILINGS; FAILURE TO COMPLY; PENALTIES.

Subdivision 1. **Annual statements.** Any insurance company licensed to do business in this state, including fraternals, reciprocals and township mutuals, which neglects to file its annual statement in the form prescribed and within the time specified by law shall be subject

to a penalty of $100 for each day in default. If, at the end of 45 days, the default has not been corrected, the company shall be given ten days in which to show cause to the commissioner why its license should not be suspended. If the company has not made the requisite showing within the ten-day period, the license and authority of the company may, at the discretion of the commissioner, be suspended during the time the company is in default.

Any insurance company, including fraternals, reciprocals, and township mutuals, willfully making a false annual or other required statement shall pay a penalty to the state not to exceed $5,000. Either or both of the monetary penalties imposed by this subdivision may be recovered in a civil action brought by and in the name of the state.

Subd. 2. **Articles of incorporation; bylaws.** Any insurance company licensed to do business in this state, including fraternals and township mutuals, which neglects to file amended bylaws or related amendments within 30 days after date of approval shall be subject to a penalty of $25 for each day in default.

Any insurance company licensed to do business in this state, including fraternals and township mutuals, which neglects to file amended articles of incorporation or related amendments within 30 days after date of approval shall be subject to a penalty of $25 for each day in default, provided that foreign insurers shall be allowed 60 days in which to file.

If after 90 days the filings required under this subdivision are still in default, the company shall be given ten days in which to show cause why its license should not be suspended.

Subd. 3. **Other filings.** Any insurance company licensed to do business in this state, including fraternals, reciprocals, and township mutuals, which neglects to comply with any other mandatory filing in the form prescribed and within the time specified by law or as specified on the document shall be subject to a penalty of $25 for each day in default. If after 90 days a default has not been corrected, the company shall be given ten days in which to show cause why its license should not be suspended.

Subd. 4. **Suspension, discretionary powers.** Any company which writes new business in this state, including fraternals, reciprocals and township mutuals, while its license is suspended and after it has been notified by the commissioner by a notice mailed to the home office of the company that its license has been suspended shall pay to the state the sum of $25 for each contract of insurance entered into by it after being notified of its license suspension. The notification shall be mailed by registered letter and deemed to have been received by the company at its home office in the usual course of the mails.

Subd. 5. **Extensions.** The commissioner may grant an extension of any filing deadline or requirement specified by this section, on receiving, not less than ten days before the date of default, satisfactory evidence of imminent hardship to the company.

Subd. 6. **Penalties; deposit to general fund.** All penalties recovered pursuant to this section shall be paid into the general fund.

History: *1977 c 316 s 1; 1984 c 592 s 71; 1986 c 444; 1991 c 325 art 10 s 10*

72A.062 [Repealed, 1982 c 622 s 5]

72A.07 VIOLATIONS OF LAWS RELATING TO AGENTS, PENALTIES.

Any person, firm, or corporation violating, or failing to comply with, any of the provisions of sections 60K.30 to 60K.56 and any person who acts in any manner in the negotiation or transaction of unlawful insurance with an insurance company not licensed to do business in the state, or who, as principal or agent, violates any provision of law relating to the negotiation or effecting of contracts of insurance, shall be guilty of a misdemeanor. Upon the filing of a complaint by the commissioner of commerce in a court of competent jurisdiction against any person violating any provisions of this section, the county attorney of the county in which the violation occurred shall prosecute the person. Upon the conviction of any agent of any violation of the provisions of sections 60K.30 to 60K.56, the commissioner shall suspend the authority of the agent to transact any insurance business within the state for a period of not less than three months. Any insurer employing an agent and failing to procure an appointment, as required by sections 60K.30 to 60K.56, or allowing the agent to transact busi-

ness for it within the state before an appointment has been procured, shall pay the commissioner, for the use of the state, a penalty of $25 for each offense. Each sale of an insurance policy by an agent who is not appointed by an insurance company shall constitute a separate offense, but no insurer shall be required to pay more than $300 in penalties as a result of the activities of a single unappointed agent. In the event of failure to pay a penalty within ten days' after notice from the commissioner, the authority of the insurer to do business in this state shall be revoked by the commissioner until the penalty is paid. No insurer whose authority is revoked shall be readmitted until it shall have complied with all the terms and conditions imposed for admission in the first instance. Any action taken by the commissioner under this section shall be subject to review by the district court of the county in which the office of the commissioner is located.

History: *1967 c 395 art 12 s 7; 1977 c 243 s 4; 1983 c 289 s 114 subd 1; 1984 c 592 s 72; 1984 c 655 art 1 s 92; 1992 c 564 art 3 s 25; 2001 c 117 art 2 s 15*

72A.08 LAWS AGAINST REBATE.

Subdivision 1. **Rebate defined and prohibited.** No insurance company or association, however constituted or entitled, including any affiliate of the insurance company or association, doing business in this state, nor any officer, agent, subagent, solicitor, employee, intermediary, or representative thereof, shall make or permit any advantage or distinction in favor of any insured individual, firm, corporation, or association with respect to the amount of premium named in, or to be paid on, any policy of insurance, or shall offer to pay or allow directly or indirectly or by means of any device or artifice, as inducements to insurance, any rebate or premium payable on the policy, or any special favor or advantage in the dividends or other profit to accrue thereon, or any valuable consideration or inducement not specified in the policy contract of insurance, or give, sell, or purchase, offer to give, sell or purchase, as inducement to insure or in connection therewith, any stocks, bonds, or other securities of any insurance company or other corporation, association, partnership, or individual, or any dividends or profits accrued or to accrue thereon, or anything of value, not specified in the policy. For purposes of this section, "affiliate" has the meaning given in section 60D.15, subdivision 2.

Subd. 2. **Insured prohibited from receiving rebates.** No person shall receive or accept from any such company or association, including any affiliate of the insurance company or association, or from any of its officers, agents, subagents, solicitors, employees, intermediaries, or representatives, or any other person any such rebate of premium payable on the policy, or any special favor or advantage in the dividends or other financial profits accrued, or to accrue, thereon, or any valuable consideration or inducement not specified in the policy of insurance. No person shall be excused from testifying, or from producing any books, papers, contracts, agreements, or documents, at the trial of any other person, copartnership, association, or company charged with violation of any provision of this section on the ground that the testimony or evidence may tend to incriminate; but no person shall be prosecuted for any act concerning which the person shall be compelled to so testify or produce evidence, documentary or otherwise, except for perjury committed in so testifying.

Subd. 3. **Penalty for rebate.** Any company, association, or individual violating any provisions of this section, whether the violation be in the giving or accepting of anything herein prohibited, shall be punished by a fine of not less than $60 nor more than $200. In the case of a violation by an affiliate or by an individual on behalf of an affiliate, this subdivision applies to the insurance company or association.

Subd. 4. **Exceptions.** The provisions of this section shall not apply to any policy procured by officers, agents, subagents, employees, intermediaries, or representatives wholly and solely upon property of which they are, respectively, the owner at the time of procuring the policy, where the officers, agents, subagents, employees, intermediaries, or representatives are, and have been for more than six months prior to the issuing of the policy, regularly employed by, or connected with, the company or association issuing the policy; and any life insurance company doing business in this state may issue industrial policies of life or endow-

ment insurance, with or without annuities, with special rates of premiums less than the usual rates of premiums for these policies, to members of labor organizations, credit unions, lodges, beneficial societies, or similar organizations, or employees of one employer, who, through their secretary or employer, may take out insurance in an aggregate of not less than 50 members and pay their premiums through the secretary or employer.

History: *1967 c 395 art 12 s 8; 1986 c 444; 1998 c 375 s 1–3; 2002 c 330 s 30,34; 2002 c 331 s 18; 2002 c 342 s 11; 2002 c 357 s 2*

72A.09 VIOLATIONS WHERE OFFENSE IS NOT SPECIFICALLY DESIGNATED.

Whoever violates any provision of the insurance law where the nature of the offense is not specifically designated herein shall be guilty, for the first offense, of a misdemeanor, and for each subsequent offense, of a gross misdemeanor.

History: *1967 c 395 art 12 s 9*

72A.10 FAILURE TO APPEAR OR OBSTRUCTING COMMISSIONER.

Whoever without justifiable cause neglects, upon due summons, to appear and testify before the commissioner, or obstructs the commissioner, or deputy or assistant commissioner, in an examination of an insurance company, shall be guilty, for the first offense, of a misdemeanor, and for each subsequent offense, of a gross misdemeanor.

History: *1967 c 395 art 12 s 10; 1986 c 444*

72A.11 COMPLAINANT ENTITLED TO ONE–HALF OF FINE IN CERTAIN CASES.

The person, other than the commissioner, or deputy or assistant commissioner, upon whose complaint a conviction is had for violation of the law prohibiting insurance in or by foreign companies not authorized to do business in this state, shall be entitled to one–half the fine recovered upon sentence therefor.

History: *1967 c 395 art 12 s 11*

72A.12 LIFE INSURANCE.

Subdivision 1. **Issue of prohibited life policies.** Every officer or agent of a life insurance company who shall issue any policy in violation of any order or other prohibition by the commissioner made pursuant to law, shall be guilty, for the first offense, of a misdemeanor, and for each subsequent offense, of a gross misdemeanor.

Subd. 2. **Misrepresentation by insurer or agent.** No life insurance company doing business in this state, and no officer, director or agent thereof, shall issue or circulate, or cause or permit to be issued or circulated, any estimate, illustration, circular or statement of any sort misrepresenting the terms of any policy issued by it or the benefits or advantages promised thereby, or the dividends or shares of surplus to be received thereon, or shall use any name or title of any policy or class of policies misrepresenting the true nature thereof.

Any person violating the provisions of this subdivision shall be guilty of a misdemeanor, and the license of any company which shall authorize or permit a violation of this subdivision shall be revoked.

Subd. 3. **Discrimination in accepting risks.** No life insurance company or agent, all other conditions being equal, shall make any discrimination in the acceptance of risks, in rates, premiums, dividends, or benefits of any kind, or by way of rebates, between persons of the same class, or on account of race; and upon request of any person whose application has been rejected, the company shall furnish the rejected applicant, in writing, the reasons therefor, including a certificate of the examining physician that such rejection was not for any racial cause. Every company violating either of the foregoing provisions shall forfeit not less than $500, nor more than $1,000, and every officer, agent, or solicitor violating the same

shall be guilty of a gross misdemeanor; and the commissioner shall revoke the license of such company and its agents, and grant no new license within one year thereafter.

Subd. 4. **Discrimination; rebates.** No life insurance company doing business in this state shall make or permit any distinction or discrimination in favor of individuals between insurants of the same class and equal expectation of life in the amount or payment of premiums or rates charged for policies of life or endowment insurance, or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of the contracts it makes; nor shall any such company or agent thereof make any contract of insurance or agreement as to such contract other than as plainly expressed in the policy issued thereon; nor shall any such company or any officer, agent, solicitor, or representative thereof pay, allow or give, or offer to pay, allow or give, directly or indirectly, as inducement to insurance, any rebate of premium payable on the policy, or any special favor or advantage in the dividends or other benefits to accrue thereon or any paid employment or contract for services of any kind, or any valuable consideration or inducement whatever not specified in the policy contract of insurance.

Any violation of the provisions of this subdivision shall be a misdemeanor and punishable as such.

Subd. 5. **Political contributions prohibited.** No insurance company or association, including fraternal benefit societies, doing business in this state, shall, directly or indirectly, pay or use, or offer, consent or agree to pay or use, any money or property for or in aid of any political party, committee or organization, or for or in aid of any corporation, joint stock or other association organized or maintained for political purposes, or for or in aid of any candidate for political office, or for nomination for the office, or for any other political purpose, or for reimbursement or indemnification of any person for money or property used for political purposes. Any officer, director, stockholder, attorney or agent of any corporation or association which violates any of the provisions of this section, who participates in, aids, abets, or advises or consents to any violation, and any person who solicits or knowingly receives any money or property in violation of this section, is guilty of a gross misdemeanor. Any officer aiding or abetting in any contribution made in violation of this section is liable to the company or association for the amount contributed. No person shall be excused from attending and testifying, or producing any books, papers or other documents before any court, upon any investigation, proceeding or trial, for a violation of any of the provisions of this section, upon the ground, or for the reason, that the testimony or evidence, documentary or otherwise, required may tend to incriminate or degrade the person. No person shall be prosecuted or subjected to any penalty or forfeiture for or on account of any transaction, matter or thing concerning which the person may testify or produce evidence, documentary or otherwise, and no testimony given or produced shall be used against that person upon any criminal investigation or proceeding.

History: *1967 c 395 art 12 s 12; 1983 c 359 s 1; 1986 c 444; 1992 c 564 art 1 s 54*

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.

(c) "Liability insurance" means insurance that provides coverage, as applicable, to renters and other authorized drivers of rental vehicles for liability arising from the operation of the rental vehicle. At the option of the auto rental company, this coverage may include uninsured or underinsured motorist coverage whether offered separately or in combination with other liability insurance.

(d) "Personal effects insurance" means coverage, as applicable, to renters and other rental vehicle occupants for the loss of, or damage to, personal effects which occurs during the rental period.

Subd. 2. **Sale by auto rental companies.** An auto rental company that offers or sells rental vehicle personal accident insurance, personal effects insurance, or liability 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 61A.02, 62A.02, or other relevant sections requiring approval of forms and rates taking into account the possible infrequency and severity of loss that may be incurred. An auto rental company offering insurance products for sale shall conduct a training program for its agents or employees, which must be submitted to the commissioner for approval. Sections 60K.30 to 60K.56 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 August 1, 1987, until they make the required filings. Each individual sale after August 1, 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 $200 per violation fine. Further, the sale of the insurance product by an auto rental company or any employee or agent of the company after August 1, 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, personal effects insurance, or liability 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 violated the insurance laws of this state and the revocation is in the public interest.

Subd. 3. **Collision damage waiver.** A "collision damage waiver" is a discharge of the responsibility of the renter or leasee to return the motor vehicle in the same condition as when it was first rented. The waiver is a full and complete discharge of the responsibility to return the vehicle in the same condition as when it was first rented. The waiver may not contain any exclusions except those approved by the commissioner.

History: *1987 c 329 s 21; 1987 c 337 s 115; 1988 c 611 s 3; 1992 c 564 art 3 s 26,29; 1999 c 177 s 69; 1999 c 236 s 2,3; 2001 c 117 art 2 s 16*

72A.13 ACCIDENT AND HEALTH INSURANCE, VIOLATIONS OF CERTAIN SECTIONS.

Subdivision 1. **Penalties.** Any company, corporation, association, society, or other insurer, or any officer or agent thereof, which or who solicits, issues or delivers to any person in this state any policy in violation of the provisions of sections 60A.06, subdivision 3 or 62A.01 to 62A.10, may be punished by a fine of not more than $200 for each offense, and the commissioner may revoke the license of any company, corporation, association, society, or other insurer of another state or country, or of the agent thereof, which or who willfully violates any provision of sections 60A.06, subdivision 3 or 62A.01 to 62A.10.

Subd. 2. [Repealed, 1989 c 330 s 37]

Subd. 3. [Repealed, 1992 c 564 art 1 s 55]

History: *1967 c 395 art 12 s 13; 1980 c 436 s 1; 1982 c 424 s 130; 1986 c 455 s 57; 1987 c 329 s 21*

72A.135 FAILURE TO FOLLOW DIVIDEND AND PRICING POLICY; PENALTIES.

An insurer failing to file and adhere to the plan required by section 61A.03, subdivision 2, paragraph (h), is subject to a civil penalty of not more than $5,000 for each violation.

History: *1983 c 292 s 3*

72A.139 USE OF GENETIC TESTS.

Subdivision 1. **Name and citation.** This section shall be known and may be cited as the "Genetic Discrimination Act."

Subd. 2. **Definitions.** (a) As used in this section, "commissioner" means the commissioner of commerce for health plan companies and other insurers regulated by that commissioner and the commissioner of health for health plan companies regulated by that commissioner.

(b) As used in this section, a "genetic test" means a presymptomatic test of a person's genes, gene products, or chromosomes for the purpose of determining the presence or absence of a gene or genes that exhibit abnormalities, defects, or deficiencies, including carrier status, that are known to be the cause of a disease or disorder, or are determined to be associated with a statistically increased risk of development of a disease or disorder. "Genetic test" does not include a cholesterol test or other test not conducted for the purpose of determining the presence or absence of a person's gene or genes.

(c) As used in this section, "health plan" has the meaning given in section 62Q.01, subdivision 3.

(d) As used in this section, "health plan company" has the meaning given in section 62Q.01, subdivision 4.

(e) As used in this section, "individual" means an applicant for coverage or a person already covered by the health plan company or other insurer.

Subd. 3. **Prohibited acts; health plan companies.** A health plan company, in determining eligibility for coverage, establishing premiums, limiting coverage, renewing coverage, or any other underwriting decision, shall not, in connection with the offer, sale, or renewal of a health plan:

(1) require or request an individual or a blood relative of the individual to take a genetic test;

(2) make any inquiry to determine whether an individual or a blood relative of the individual has taken or refused a genetic test, or what the results of any such test were;

(3) take into consideration the fact that a genetic test was taken or refused by an individual or blood relative of the individual; or

(4) take into consideration the results of a genetic test taken by an individual or a blood relative of the individual.

Subd. 4. **Application.** Subdivisions 5, 6, and 7 apply only to a life insurance company or fraternal benefit society requiring a genetic test for the purpose of determining insurability under a policy of life insurance.

Subd. 5. **Informed consent.** If an individual agrees to take a genetic test, the life insurance company or fraternal benefit society shall obtain the individual's written informed consent for the test. Written informed consent must include, at a minimum, a description of the specific test to be performed; its purpose, potential uses, and limitations; the meaning of its results; and the right to confidential treatment of the results. The written informed consent must inform the individual that the individual should consider consulting with a genetic counselor prior to taking the test and must state whether the insurer will pay for any such consultation. An informed consent disclosure form must be approved by the commissioner prior to its use.

Subd. 6. **Notification.** The life insurance company or fraternal benefit society shall notify an individual of a genetic test result by notifying the individual or the individual's designated physician. If the individual tested has not given written consent authorizing a physician to receive the test results, the individual must be urged, at the time that the individual is informed of the genetic test result described in this subdivision, to contact a genetic counselor or other health care professional.

Subd. 7. **Payment for test.** A life insurance company or fraternal benefit society shall not require an individual to submit to a genetic test unless the cost of the test is paid by the life insurance company or fraternal benefit society.

Subd. 8. **Enforcement.** A violation of this section is subject to the investigative and enforcement authority of the commissioner, who shall enforce this section.

History: *1995 c 251 s 1*

72A.14 [Renumbered 65B.13]

72A.141 [Renumbered 65B.14]

72A.142 [Renumbered 65B.15]

72A.143 [Renumbered 65B.16]

72A.144 [Renumbered 65B.17]

72A.145 [Renumbered 65B.18]

72A.146 [Renumbered 65B.19]

72A.147 [Renumbered 65B.20]

72A.148 [Renumbered 65B.21]

72A.149 [Renumbered 65B.22]

72A.1491 [Renumbered 65B.23]

72A.1492 [Renumbered 65B.24]

72A.1493 [Renumbered 65B.25]

72A.1494 [Renumbered 65B.26]

72A.1495 [Renumbered 65B.27]

72A.15 PENALTY FOR VIOLATION OF LAW PROVIDING FOR INSURANCE IN UNLICENSED COMPANIES.

Every person licensed to procure insurance in an unlicensed foreign company who fails to file the affidavit and statement required in such case or who willfully makes a false affidavit or statement shall forfeit the license and be guilty, for the first offense, of a misdemeanor, and for each subsequent offense, of a gross misdemeanor.

History: *1967 c 395 art 12 s 15; 1986 c 444*

72A.16 MUTUAL COMPANIES.

Subdivision 1. **Unlawful procurement or use of proxy.** Every officer or agent of a domestic mutual insurance company who shall solicit, receive, procure to be obtained, or use, a proxy vote in violation of any provision of law shall be guilty of a gross misdemeanor.

Subd. 2. **Guaranty against assessment.** Every director, officer, or agent of an insurance company who officially or privately gives a guaranty to a policyholder thereof against an assessment for which the policyholder would otherwise be liable shall be guilty of a misdemeanor.

History: *1967 c 395 art 12 s 16; 1986 c 444*

REGULATION OF TRADE PRACTICES

72A.17 PURPOSE OF SECTIONS 72A.17 TO 72A.32.

The purpose of sections 72A.17 to 72A.32 is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945 (Public Law 15, 79th Congress), by defining, or providing for the determination of, all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

History: *1967 c 395 art 12 s 17*

72A.18 DEFINITIONS.

Subdivision 1. **General.** Unless the context clearly indicates otherwise, the following terms, when used in sections 72A.17 to 72A.32, shall have the meanings respectively ascribed to them in this section.

Subd. 2. **Person.** "Person" means any individual, corporation, association, partnership, reciprocal exchange, interinsurer, Lloyds insurer, fraternal benefit society, or any other legal entity, engaged in the business of insurance, including an agent, a solicitor, or an adjuster and for the purposes of sections 72A.31 and 72A.32 "person" shall in addition mean any person, firm or corporation even though not engaged in the business of insurance.

History: *1967 c 395 art 12 s 18*

72A.19 UNFAIR METHODS AND UNFAIR OR DECEPTIVE ACTS AND PRACTICES.

Subdivision 1. **Prohibition.** No person shall engage in this state in any trade practice which is defined in sections 72A.17 to 72A.32 as or determined pursuant to sections 72A.17 to 72A.32 to be an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.

Subd. 2. **Rulemaking.** The commissioner may, in accordance with chapter 14, promulgate reasonable rules as the commissioner deems necessary to enforce and administer the provisions of this chapter.

History: *1967 c 395 art 12 s 19; 1980 c 436 s 2; 1982 c 424 s 130; 1985 c 248 s 70; 1986 c 444*

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

Subdivision 1. **Misrepresentations and false advertising of policy contracts.** Making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular, or statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon, or making any false or misleading statement as to the dividends or share of surplus previously paid on similar policies, or making any misleading representation or any

misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates, or using any name or title of any policy or class of policies misrepresenting the true nature thereof, or making any misrepresentation to any policyholder insured in any company for the purpose of inducing or tending to induce such policyholder to lapse, forfeit, or surrender insurance, shall constitute an unfair method of competition and an unfair and deceptive act or practice in the business of insurance.

Subd. 2. **False information and advertising generally.** Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station, or in any other way, an advertisement, announcement, or statement, containing any assertion, representation, or statement with respect to the business of insurance, or with respect to any person in the conduct of the person's insurance business, which is untrue, deceptive, or misleading, shall constitute an unfair method of competition and an unfair and deceptive act or practice.

Subd. 3. **Defamation.** Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature which is false, or maliciously critical of or derogatory to the financial condition of an insurer, and which is calculated to injure any person engaged in the business of insurance, shall constitute an unfair method of competition and an unfair and deceptive act or practice.

Subd. 4. **Boycott, coercion, and intimidation.** Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion, or intimidation, resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance, shall constitute an unfair method of competition and an unfair and deceptive act or practice.

Subd. 4a. [Renumbered 72A.201, subd 4a]

Subd. 5. **False financial statements.** Filing with any supervisory or other public official, or making, publishing, disseminating, circulating, or delivering to any person, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false statement of financial condition of an insurer with intent to deceive, shall constitute an unfair method of competition and an unfair and deceptive act or practice in the insurance business.

Subd. 6. **False entries.** Making any false entry in any book, report, or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to whom such insurer is required by law to report, or who has authority by law to examine into its condition or into any of its affairs, or, with like intent, willfully omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report, or statement of such insurer, shall constitute an unfair method of competition and an unfair and deceptive act or practice.

Subd. 7. **Stock operations and advisory board contracts.** Issuing or delivering, or permitting agents, officers, or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any common–law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insurance, shall constitute an unfair method of competition and an unfair and deceptive act or practice.

Subd. 8. **Discrimination.** (a) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract or in making or permitting the rejection of an individual's application for life insurance coverage, as well as the determination of the rate class for such individual, on the basis of a disability, shall constitute an unfair method of competition and an unfair and deceptive act or practice, unless the claims experience and ac-

tuarial projections and other data establish significant and substantial differences in class rates because of the disability.

(b) Refusing to insure or refusing to continue to insure the life of a member of a reserve component of the armed forces of the United States, or the National Guard due to that person's status as a member, or duty assignment while a member of any of these military organizations, constitutes an unfair method of competition and an unfair and deceptive act or practice unless the individual has received an order for active duty.

(c) Refusing to reinstate coverage for the insured or any covered dependents under an individual or group life or health insurance policy or contract of a member of a reserve component of the armed forces of the United States or the National Guard whose coverage or dependent coverage was terminated, canceled, or nonrenewed while that person was on active duty constitutes an unfair method of competition and an unfair and deceptive act or practice. For purposes of paragraphs (a) to (c), "health insurance policy or contract" means any policy, contract, or certificate providing benefits regulated under chapter 62A, 62C, 62D, or 64B.

For purposes of reinstatement of an individual policy, the person shall apply for reinstatement within 90 days after removal from active duty.

The reinstated coverage must not contain any new preexisting condition or other exclusion or limitation, except a condition determined by the Veterans Administration to be a disability incurred or aggravated in the line of duty. The remainder of a preexisting condition limitation that was not satisfied before the coverage was terminated may be applied once the person returns and coverage is reinstated. Reinstatement is effective upon the payment of any required premiums.

(d) Refusing to offer, sell, or renew coverage; limiting coverage; or charging a rate different from that normally charged for the same coverage under a life insurance policy or health plan because the applicant who is also the proposed insured has been or is a victim of domestic abuse is an unfair method of competition and an unfair and deceptive act or practice.

Nothing in this paragraph prevents an insurer from underwriting a risk on the basis of the physical or mental history of an individual if the insurer does not take into consideration whether the individual's condition was caused by an act of domestic abuse.

For purposes of this paragraph, "domestic abuse" has the meaning given in section 518B.01, subdivision 2; and "health plan" has the meaning given in section 62Q.01, subdivision 3, and includes the coverages referred to in section 62A.011, subdivision 3, clauses (1), (7), (9), and (10).

Subd. 9. **Discrimination between individuals of the same class.** Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever, or in making or permitting the rejection of an individual's application for accident or health insurance coverage, as well as the determination of the rate class for such individual, on the basis of a disability, shall constitute an unfair method of competition and an unfair and deceptive act or practice, unless the claims experience and actuarial projections and other data establish significant and substantial differences in class rates because of the disability.

Subd. 10. **Rebates.** Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any contract of life insurance, annuity, or accident and health insurance, or agreement as to such contract, other than as plainly expressed in the contract issued thereon, or paying or allowing or giving, or offering to pay, allow, or give, directly or indirectly, as inducement to such insurance or annuity, any rebate of premiums payable on the contract, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract; or giving or selling or purchasing, or offering to give, sell, or purchase, as inducement to such insurance or annuity, or in connection therewith, any stocks, bonds, or other securities of any in-

surance company or other corporation, association, or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract, shall constitute an unfair method of competition and an unfair and deceptive act or practice.

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 sections 72A.08, subdivision 4, 72A.201, sections 72A.49 to 72A.505, and 65B.13.

Subd. 12. **Unfair service.** Causing or permitting with such frequency to indicate a general business practice any unfair, deceptive, or fraudulent act concerning any claim or complaint of an insured or claimant including, but not limited to, the following practices:

(1) misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

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

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

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

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

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

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

(8) attempting to settle a claim for less than the amount to which reasonable persons would have believed they were entitled by reference to written or printed advertising material accompanying or made part of an application;

(9) attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of, the insured;

(10) making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which the payments are being made;

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

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

(13) failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage;

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

(15) requiring an insured to provide information or documentation that is or would be dated more than five years prior to or five years after the date of a fire loss, except for proof of ownership of the damaged property.

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

Subd. 13. **Refusal to renew.** Refusing to renew, declining to offer or write, or charging differential rates for an equivalent amount of homeowner's insurance coverage, as defined

by section 65A.27, for property located in a town or statutory or home rule charter city, in which the insurer offers to sell or writes homeowner's insurance, solely because:

(a) of the geographic area in which the property is located;

(b) of the age of the primary structure sought to be insured;

(c) the insured or prospective insured was denied coverage of the property by another insurer, whether by cancellation, nonrenewal or declination to offer coverage, for a reason other than those specified in section 65A.01, subdivision 3a, clauses (a) to (e);

(d) the property of the insured or prospective insured has been insured under the Minnesota FAIR Plan Act, shall constitute an unfair method of competition and an unfair and deceptive act or practice; or

(e) the insured has inquired about coverage for a hypothetical claim or has made an inquiry to the insured's agent regarding a potential claim.

This subdivision prohibits an insurer from filing or charging different rates for different zip code areas within the same town or statutory or home rule charter city.

This subdivision shall not prohibit the insurer from applying underwriting or rating standards which the insurer applies generally in all other locations in the state and which are not specifically prohibited by clauses (a) to (e). Such underwriting or rating standards shall specifically include but not be limited to standards based upon the proximity of the insured property to an extraordinary hazard or based upon the quality or availability of fire protection services or based upon the density or concentration of the insurer's risks. Clause (b) shall not prohibit the use of rating standards based upon the age of the insured structure's plumbing, electrical, heating or cooling system or other part of the structure, the age of which affects the risk of loss. Any insurer's failure to comply with section 65A.29, subdivisions 2 to 4, either (1) by failing to give an insured or applicant the required notice or statement or (2) by failing to state specifically a bona fide underwriting or other reason for the refusal to write shall create a presumption that the insurer has violated this subdivision.

Subd. 14. **Application form refusal.** An insurance agent refusing to supply a requested application form for homeowner's insurance with any insurer whom the agent represents or refusing to transmit forthwith any completed application form to the insurer, shall constitute an unfair method of competition and an unfair and deceptive act or practice.

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 sup-

plement 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.

If the commissioner requests copies of contracts with a provider under this clause and the provider requests a determination, all information contained in the contracts that the commissioner determines may place the provider or health care plan at a competitive disadvantage is nonpublic data.

Subd. 16. **Discrimination based on sex or marital status.** Refusing to insure, refusing to continue to insure, refusing to offer or submit an application for coverage, or limiting the amount of coverage available to an individual because of the sex or marital status of the individual; however, nothing in this subsection prohibits an insurer from taking marital status into account for the purpose of defining persons eligible for dependents' benefits.

Subd. 17. **Return of premiums.** (a) Refusing, upon surrender of an individual policy of life insurance in the case of the insured's death, or in the case of a surrender prior to death, of an individual insurance policy not covered by the standard nonforfeiture laws under section 61A.24, to refund to the owner all unearned premiums paid on the policy covering the insured as of the time of the insured's death or surrender if the unearned premium is for a period of more than one month. The return of unearned premium must be delivered to the insured within 30 days following receipt by the insurer of the insured's request for cancellation.

(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 return of unearned premium must be delivered to the insured within 30 days following receipt by the insurer of the insured's request for cancellation.

(c) This subdivision does not apply to policies of insurance providing coverage only for motorcycles or other seasonally rated or limited use vehicles where the rate is reduced to reflect seasonal or limited use.

(d) 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. Except for premiums for motorcycle coverage or other seasonally rated or limited use vehicles where the rate is reduced to reflect seasonal or limited use, the unearned premium is determined by multiplying the premium by the fraction that results from dividing the period of time from the date of termination to the date the next scheduled premium is due by the period of time for which the premium was paid.

(e) The owner may cancel a policy referred to in this section at any time during the policy period. This provision supersedes any inconsistent provision of law or any inconsistent policy provision.

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.

Subd. 20. **Contact with government.** An insurance company may not terminate or otherwise penalize an insurance agent solely because the agent contacted any government department or agency regarding a problem that the agent or an insured may be having with an insurance company. For purposes of this section, "government department or agency" includes the executive, legislative, and judicial branches of government as stated in article III of the Constitution.

Subd. 21. **Prohibited selection or underwriting practice.** No insurance company doing business in this state shall engage in any selection or underwriting practice that is arbitrary, capricious, or unfairly discriminatory.

Subd. 22. **Limitations on health care providers.** (a) No insurer providing benefits under the Minnesota No–Fault Automobile Insurance Act or a plan authorized by sections 471.617 or 471.98 to 471.982 may limit the type of licensed health care provider who may provide treatment for covered conditions under a policy so long as the services provided are within the scope of licensure for the provider. The insurer may not exclude a specific method of treatment for a covered condition if that exclusion has the effect of excluding a specific type of licensed health care provider from treating a covered condition.

(b) This subdivision does not limit the right of an insurer to contract with individual members of any type of licensed health care provider to the exclusion of other members of the group, nor shall it limit the right to the insurer to exclude coverage for a type of treatment if the insurer can show the treatment is not medically necessary or is not medically appropriate.

Subd. 23. **Discrimination in automobile insurance policies.** (a) No insurer that offers an automobile insurance policy in this state shall:

(1) use the employment status of the applicant as an underwriting standard or guideline; or

(2) deny coverage to a policyholder for the same reason.

(b) No insurer that offers an automobile insurance policy in this state shall:

(1) use the applicant's status as a residential tenant, as the term is defined in section 504B.001, subdivision 12, as an underwriting standard or guideline; or

(2) deny coverage to a policyholder for the same reason; or

(3) make any discrimination in offering or establishing rates, premiums, dividends, or benefits of any kind, or by way of rebate, for the same reason.

(c) No insurer that offers an automobile insurance policy in this state shall:

(1) use the failure of the applicant to have an automobile policy in force during any period of time before the application is made as an underwriting standard or guideline; or

(2) deny coverage to a policyholder for the same reason.

Paragraph (c) does not apply if the applicant was required by law to maintain automobile insurance coverage and failed to do so.

An insurer may require reasonable proof that the applicant did not fail to maintain this coverage. The insurer is not required to accept the mere lack of a conviction or citation for failure to maintain this coverage as proof of failure to maintain coverage. The insurer must provide the applicant with information identifying the documentation that is required to establish reasonable proof that the applicant did not fail to maintain the coverage.

(d) No insurer that offers an automobile insurance policy in this state shall use an applicant's prior claims for benefits paid under section 65B.44 as an underwriting standard or guideline if the applicant was 50 percent or less negligent in the accident or accidents causing the claims.

(e) No insurer shall refuse to issue any standard or preferred policy of motor vehicle insurance or make any discrimination in the acceptance of risks, in rates, premiums, dividends, or benefits of any kind, or by way of rebate:

(1) between persons of the same class, or

(2) on account of race, or

(3) on account of physical disability if the disability is compensated for by special training, equipment, prosthetic device, corrective lenses, or medication and if the physically disabled person:

(i) is licensed by the Department of Public Safety to operate a motor vehicle in this state, and

(ii) operates only vehicles that are equipped with auxiliary devices and equipment necessary for safe and effective operation by the disabled person, or

(4) on account of marital dissolution.

Subd. 24. **Cancellations and nonrenewals.** No insurer shall cancel or fail to renew an individual life or individual health policy or an individual nonprofit health service plan subscriber contract for nonpayment of premium unless it mails or delivers to the named insured, at the address shown on the policy or subscriber contract at least 30 days before lapse, final notice of the cancellation or nonrenewal and the effective date of the cancellation or nonrenewal.

If the named insured is not the policy or subscriber contract owner, the notice required by this subdivision must be sent to the insured's last known address, if any, and to the owner's last known address.

Proof of mailing of the notice of lapse for failure to pay the premium before the expiration of the grace period is sufficient proof that notice required in this subdivision has been given.

This subdivision does not apply to a life or health insurance policy or contract upon which premiums are paid at a monthly interval or less and that contains any grace period required by statute for the payment of premiums during which time the insurance continues in force.

Subd. 25. **Use of statements of a minor.** No statement of a minor or information obtained by an insurer or a representative of an insurer from a minor may be used in any manner in regard to a claim unless the parent or guardian of the minor has granted permission for the minor to be interviewed or the minor's statement to be taken.

Subd. 26. **Loss experience.** An insurer shall without cost to the insured provide an insured with the loss or claims experience of that insured for the current policy period and for the two policy periods preceding the current one for which the insurer has provided coverage, within 30 days of a request for the information by the policyholder. Claims experience data must be provided to the insured in accordance with state and federal requirements regarding the confidentiality of medical data. The insurer shall not be responsible for providing information without cost more often than once in a 12–month period. The insurer is not required to provide the information if the policy covers the employee of more than one employer and the information is not maintained separately for each employer and not all employers request the data.

An insurer, health maintenance organization, or a third–party administrator may not request more than three years of loss or claims experience as a condition of submitting an application or providing coverage.

This subdivision only applies to group life policies and group health policies.

Subd. 27. **Solicitations and sales of insurance products to borrowers.** (a) A loan officer, a loan representative, or other person involved in taking or processing a loan may not solicit an insurance product, except for credit life, credit disability, credit involuntary unemployment, mortgage life, mortgage accidental death, or mortgage disability, and except for life insurance when offered in lieu of credit life insurance, from the completion of the initial loan application, as defined in the federal Equal Credit Opportunity Act, United States Code,

title 15, sections 1691 to 1691f, and any regulations adopted under those sections, until after the closing of the loan transaction.

(b) This subdivision applies only to loan transactions covered by the federal Truth–in–Lending Act, United States Code, title 15, sections 1601 to 1666j, and any regulations adopted under those sections.

(c) This subdivision does not apply to sales of title insurance, homeowner's insurance, a package homeowner's–automobile insurance product, automobile insurance, or a similar insurance product, required to perfect title to, or protect, property for which a security interest will be taken if the product is required as a condition of the loan.

(d) Nothing in this subdivision prohibits the solicitation or sale of any insurance product by means of mass communication.

Subd. 28. **Conversion fees prohibited.** An issuer providing health coverage through conversion policies, plans, or contracts shall not impose a fee or charge, other than the premium, for issuing these policies, plans, or contracts.

Subd. 29. **HIV tests; crime victims and emergency medical service personnel.** No insurer regulated under chapter 61A, 62B, or 62S, or providing health, medical, hospitalization, long–term care insurance, or accident and sickness insurance regulated under chapter 62A, or nonprofit health service plan corporation regulated under chapter 62C, health maintenance organization regulated under chapter 62D, or fraternal benefit society regulated under chapter 64B, may:

(1) use the results of a test to determine the presence of the human immunodeficiency virus (HIV) antibody performed on an offender under section 611A.19 or performed on a crime victim who was exposed to or had contact with an offender's bodily fluids during commission of a crime that was reported to law enforcement officials, in order to make an underwriting decision, cancel, fail to renew, or take any other action with respect to a policy, plan, certificate, or contract;

(2) use the results of a test to determine the presence of a bloodborne pathogen performed on an individual according to sections 144.7401 to 144.7415, 241.33 to 241.342, or 246.71 to 246.722 in order to make an underwriting decision, cancel, fail to renew, or take any other action with respect to a policy, plan, certificate, or contract; or

(3) ask an applicant for coverage or a person already covered whether the person has: (i) had a test performed for the reason set forth in clause (1) or (2); or (ii) been the victim of an assault or any other crime which involves bodily contact with the offender.

This subdivision does not affect tests conducted for purposes other than those described in clause (1) or (2), including any test to determine the presence of a bloodborne pathogen if such test was performed at the insurer's direction as part of the insurer's normal underwriting requirements.

Subd. 29a. **HIV tests; vaccine research.** (a) No insurer regulated under chapter 61A or 62B, or providing health, medical, hospitalization, or accident and sickness insurance regulated under chapter 62A, or nonprofit health services corporation regulated under chapter 62C, health maintenance organization regulated under chapter 62D, or fraternal benefit society regulated under chapter 64B, may make an underwriting decision, cancel, fail to renew, or take any other action with respect to a policy, plan, certificate, or contract based solely on the fact of a person's participation in a human immunodeficiency virus (HIV) vaccine clinical trial.

(b) If a test to determine the presence of the HIV antibody is performed at the insurer's direction, as part of the insurer's normal underwriting requirements or on any other basis, and an applicant or covered person is a participant or former participant in a vaccine clinical trial and tests positive for the HIV antibody in the insurer–directed test, the person shall disclose the person's status as a participant or former participant in a vaccine clinical trial and provide the insurance company with certification from the trial sponsor of the person's participation or former participation in the vaccine trial. Upon that notification, an insurer shall stay any adverse decision or refrain from making an underwriting decision to cancel, fail to

renew, or take any other action based solely on the positive test result until the insurer obtains a confidential certificate from the sponsor of the trial verifying the person's HIV status. If the confidential certificate indicates that the person's HIV antibodies are a result of exposure to the vaccine, that the person does not have the HIV virus, and that the person did not test positive for the HIV virus in any test administered by the trial sponsor prior to entering the vaccine clinical trial, the insurer shall ignore the presence of the HIV antibody in the insurer–directed test.

(c) This subdivision does not affect any tests to determine the presence of the HIV antibody, except as provided under paragraph (b).

(d) This subdivision does not apply to persons who are confirmed as having the HIV virus.

(e) For purposes of this subdivision, "vaccine clinical trial" means a clinical trial conducted by a sponsor under an investigational new drug application as provided by Code of Federal Regulations, title 21, section 312. "Sponsor" means the hospital, clinic, or health care professional that is conducting the vaccine clinical trial.

Subd. 30. **Records retention.** An insurer shall retain copies of all underwriting documents, policy forms, and applications for three years from the effective date of the policy. An insurer shall retain all claim files and documentation related to a claim for three years from the date the claim was paid or denied. This subdivision does not relieve the insurer of its obligation to produce these documents to the department after the retention period has expired in connection with an enforcement action or administrative proceeding against the insurer from whom the documents are requested, if the insurer has retained the documents. Records required to be retained by this section may be retained in paper, photograph, microprocess, magnetic, mechanical, or electronic media, or by any process which accurately reproduces or forms a durable medium for the reproduction of a record.

Subd. 31. **Reasonable, adequate, and not predatory premiums.** Premiums charged by a health plan company, as defined in section 62Q.01, shall be reasonable, adequate, and not predatory in relation to the benefits, considering actuarial projection of the cost of providing or paying for the covered health services, considering the costs of administration, and in relation to the reserves and surplus required by law.

Subd. 32. **Unfair health risk avoidance.** No insurer or health plan company may design a network of providers, policies on access to providers, or marketing strategy in such a way as to discourage enrollment by individuals or groups whose health care needs are perceived as likely to be more expensive than the average. This subdivision does not prohibit underwriting and rating practices that comply with Minnesota law.

Subd. 33. **Prohibition of inappropriate incentives.** No insurer or health plan company may give any financial incentive to a health care provider based solely on the number of services denied or referrals not authorized by the provider. This subdivision does not prohibit capitation or other compensation methods that serve to hold health care providers financially accountable for the cost of caring for a patient population.

Subd. 34. **Suitability of insurance for customer.** In recommending or issuing life, endowment, individual accident and sickness, long–term care, annuity, life–endowment, or Medicare supplement insurance to a customer, an insurer, either directly or through its agent, must have reasonable grounds for believing that the recommendation is suitable for the customer.

In the case of group insurance marketed on a direct response basis without the use of direct agent contact, this subdivision is satisfied if the insurer has reasonable grounds to believe that the insurance offered is generally suitable for the group to whom the offer is made.

Subd. 35. **Determination of health plan policy limits.** Any health plan that includes a specific policy limit within its insurance policy, certificate, or subscriber agreement shall calculate the policy limit by using the amount actually paid on behalf of the insured, subscriber, or dependents for services covered under the policy, subscriber agreement, or certificate unless the amount paid is greater than the billed charge.

Subd. 36. **Limitations on the use of credit information.** (a) No insurer or group of affiliated insurers may reject, cancel, or nonrenew a policy of private passenger motor vehicle insurance as defined under section 65B.01 or a policy of homeowner's insurance as defined under section 65A.27, for any person in whole or in part on the basis of credit information, including a credit reporting product known as a "credit score" or "insurance score," without consideration and inclusion of any other applicable underwriting factor.

(b) If credit information, credit scoring, or insurance scoring is to be used in underwriting, the insurer must disclose to the consumer that credit information will be obtained and used as part of the insurance underwriting process.

(c) Insurance inquiries and non–consumer–initiated inquiries must not be used as part of the credit scoring or insurance scoring process.

(d) If a credit score, insurance score, or other credit information relating to a consumer, with respect to the types of insurance referred to in paragraph (a), is adversely impacted or cannot be generated because of the absence of a credit history, the insurer must exclude the use of credit as a factor in the decision to reject, cancel, or nonrenew.

(e) Insurers must upon the request of a policyholder reevaluate the policyholder's score. Any change in premium resulting from the reevaluation must be effective upon the renewal of the policy. An insurer is not required to reevaluate a policyholder's score pursuant to this paragraph more than twice in any given calendar year.

(f) Insurers must upon request of the applicant or policyholder provide reasonable underwriting exceptions based upon prior credit histories for persons whose credit information is unduly influenced by expenses related to a catastrophic injury or illness, temporary loss of employment, or the death of an immediate family member. The insurer may require reasonable documentation of these events prior to granting an exception.

(g) A credit scoring or insurance scoring methodology must not be used by an insurer if the credit scoring or insurance scoring methodology incorporates the gender, race, nationality, or religion of an insured or applicant.

(h) Insurers that employ a credit scoring or insurance scoring system in underwriting of coverage described in paragraph (a) must have on file with the commissioner:

(1) the insurer's credit scoring or insurance scoring methodology; and

(2) information that supports the insurer's use of a credit score or insurance score as an underwriting criterion.

(i) Insurers described in paragraph (g) shall file the required information with the commissioner within 120 days of August 1, 2002, or prior to implementation of a credit scoring or insurance scoring system by the insurer, if that date is later.

(j) Information provided by, or on behalf of, an insurer to the commissioner under this subdivision is trade secret information under section 13.37.

Subd. 37. **Electronic transmission of required information.** A health carrier, as defined in section 62A.011, subdivision 2, is not in violation of this chapter for electronically transmitting or electronically making available information otherwise required to be delivered in writing under chapters 62A to 62Q and 72A to an enrollee as defined in section 62Q.01, subdivision 2a, and with the requirements of those chapters if the following conditions are met:

(1) the health carrier informs the enrollee that electronic transmission or access is available and, at the discretion of the health carrier, the enrollee is given one of the following options:

(i) electronic transmission or access will occur only if the enrollee affirmatively requests to the health carrier that the required information be electronically transmitted or available and a record of that request is retained by the health carrier; or

(ii) electronic transmission or access will automatically occur if the enrollee has not opted out of that manner of transmission by request to the health carrier and requested that the information be provided in writing. If the enrollee opts out of electronic transmission, a record of that request must be retained by the health carrier;

(2) the enrollee is allowed to withdraw the request at any time;

(3) if the information transmitted electronically contains individually identifiable data, it must be transmitted to a secured mailbox. If the information made available electronically contains individually identifiable data, it must be made available at a password–protected secured Web site;

(4) the enrollee is provided a customer service number on the enrollee's member card that may be called to request a written copy of the document; and

(5) the electronic transmission or electronic availability meets all other requirements of this chapter including, but not limited to, size of the typeface and any required time frames for distribution.

Subd. 38. **Unfair claims service; service contracts.** No person shall, in connection with a service contract regulated under chapter 59B:

(1) attempt to settle claims on the basis of an application or any other material document which was altered without notice to, or knowledge or consent of, the service contract holder;

(2) make a material misrepresentation to the service contract holder for the purpose and with the intent of effecting settlement of the claims, loss, or damage under the contract on less favorable terms than those provided in, and contemplated by, the contract; or

(3) commit or perform with such frequency as to indicate a general business practice any of the following practices:

(i) failure to properly investigate claims;

(ii) misrepresentation of pertinent facts or contract provisions relating to coverages at issue;

(iii) failure to acknowledge and act upon communications within a reasonable time with respect to claims;

(iv) denial of claims without conducting reasonable investigations based upon available information;

(v) failure to affirm or deny coverage of claims upon written request of the service contract holder within a reasonable time after proof–of–loss statements have been completed; or

(vi) failure to timely provide a reasonable explanation to the service contract holder of the basis in the contract in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

Subd. 39. **Discounted payments by health care providers; effect on use of usual and customary payments.** An insurer, including, but not limited to, a health plan company as defined in section 62Q.01, subdivision 4; a reparation obligor as defined in section 65B.43, subdivision 9; and a workers' compensation insurer shall not consider in determining a health care provider's usual and customary payment, standard payment, or allowable payment used as a basis for determining the provider's payment by the insurer, the following discounted payment situations:

(1) care provided to relatives of the provider;

(2) care for which a discount or free care is given in hardship situations; and

(3) care for which a discount is given in exchange for cash payment.

For purposes of this subdivision, "health care provider" and "provider" have the meaning given in section 62J.03, subdivision 8.

History: *1967 c 395 art 12 s 20; 1973 c 474 s 1; 1975 c 139 s 1; 1979 c 207 s 6; 1Sp1981 c 4 art 2 s 7; 1983 c 285 s 1; 1984 c 555 s 1–3; 1984 c 592 s 73; 1Sp1985 c 10 s 71; 1986 c 444; 1987 c 113 s 1; 1987 c 337 s 116–119; 1989 c 170 s 3; 1989 c 260 s 17–20; 1989 c 316 s 1; 1989 c 330 s 27–32; 1990 c 467 s 1; 1991 c 188 s 1; 1992 c 524 s 1; 1992 c 564 art 1 s 46,54; art 4 s 14; 1992 c 569 s 6; 1993 c 343 s 26; 1994 c 475 s 1; 1994 c 485 s 54,55,65; 1994 c 625 art 3 s 20; 1995 c 186 s 17; 1995 c 234 art 8 s 21,22; 1995 c 258 s 52,53; 1996 c 278 s 1; 1996 c 433 s 1; 1996 c 446 art 1 s 61–65; 1997 c 77 s 3; 1999 c 121 s 1; 1999 c 177 s 70; 1999 c 199 art 2 s 1; 2000 c 422 s 3; 2000 c 483 s 21,22; 2001 c 28 s 1; 2002 c 357 s 1; 2004 c 268 s 11; 2004 c 288 art 7 s 4; 2005 c 56 s 1; 2005 c 132 s 22,23; 1Sp2005 c 1 art 5 s 12; 2006 c 255 s 59*

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 sections 60K.30 to 60K.56, 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)(i) unless provided otherwise by clause (ii) or (iii), other 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;

(ii) for claims submitted under a health policy, the insurer must comply with all of the requirements of section 62Q.75;

(iii) for claims submitted under a health policy that are accepted, the insurer must notify the insured or claimant no less than semiannually of the disposition of claims of the insured or claimant. For purposes of this clause, acceptance of a claim means that there is no additional financial liability for the insured or claimant, either because there is a flat co–payment

amount specified in the health plan or because there is no co–payment, deductible, or coinsurance owed;

(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. 4a. **Standards for preauthorization approval.** If a policy of accident and sickness insurance or a subscriber contract requires preauthorization approval for any nonemergency services or benefits, the decision to approve or disapprove the requested services or benefits must be processed in accordance with section 62M.07.

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) notwithstanding any inconsistent provision of section 65A.01, subdivision 3, 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, except that when an insurer is recovering directly from an uninsured third party by means of installments, the insured must receive the full deductible share as soon as that amount is collected and before any part of the total recovery is applied to any other use. 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. An insured is not bound by any settlement of its insurer's subrogation claim with respect to the deductible amount, unless the insured receives, as a result of the subrogation settlement, the full amount of the deductible. Recovery by the insurer and receipt by the insured of less than all of the insured's deductible amount does not affect the insured's rights to recover any unreimbursed portion of the deductible from parties liable for the loss;

(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 or engaging in any act or practice of intimidation, coercion, threat, incentive, or inducement for or against an insured to use a particular contractor or repair shop. Consumer benefits included within preferred vendor programs must not be considered an incentive or inducement. At the time a claim is reported, the insurer must provide the following advisory to the insured or claimant:

"You have the legal right to choose a repair shop to fix your vehicle. Your policy will cover the reasonable costs of repairing your vehicle to its pre–accident condition no matter where you have repairs made. Have you selected a repair shop or would you like a referral?"

After an insured has indicated that the insured has selected a repair shop, the insurer must cease all efforts to influence the insured's or claimant's choice of repair shop;

(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;

(13) failing to provide, to an insured who has submitted a claim for benefits described in section 65B.44, a complete copy of the insurer's claim file on the insured, excluding internal company memoranda, all materials that relate to any insurance fraud investigation, materials that constitute attorney work–product or that qualify for the attorney–client privilege, and medical reviews that are subject to section 145.64, within ten business days of receiving a written request from the insured. The insurer may charge the insured a reasonable copying fee. This clause supersedes any inconsistent provisions of sections 72A.49 to 72A.505;

(14) if an automobile policy provides for the adjustment or settlement of an automobile loss due to damaged window glass, failing to provide payment to the insured's chosen vendor based on a competitive price that is fair and reasonable within the local industry at large. Where facts establish that a different rate in a specific geographic area actually served by the vendor is required by that market, that geographic area must be considered. This clause does not prohibit an insurer from recommending a vendor to the insured or from agreeing with a vendor to perform work at an agreed–upon price, provided, however, that before recommending a vendor, the insurer shall offer its insured the opportunity to choose the vendor. If the insurer recommends a vendor, the insurer must also provide the following advisory:

"Minnesota law gives you the right to go to any glass vendor you choose, and prohibits me from pressuring you to choose a particular vendor.";

(15) requiring that the repair or replacement of motor vehicle glass and related products and services be made in a particular place or shop or by a particular entity, or by otherwise limiting the ability of the insured to select the place, shop, or entity to repair or replace the motor vehicle glass and related products and services; or

(16) engaging in any act or practice of intimidation, coercion, threat, incentive, or inducement for or against an insured to use a particular company or location to provide the motor vehicle glass repair or replacement services or products. For purposes of this section, a warranty shall not be considered an inducement or incentive.

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;

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

(iv) if the denied claim is a fire claim, the insured's right to file with the Department of Commerce a complaint regarding the denial, and the address and telephone number of the Department of Commerce;

(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;

(7) denying a claim by an insured or claimant based on the evaluation of a chemical dependency claim reviewer selected by the insurer unless the reviewer meets the qualifications specified under subdivision 8a. An insurer that selects chemical dependency reviewers to conduct claim evaluations must annually file with the commissioner of commerce a report containing the specific evaluation standards and criteria used in these evaluations. The report must be filed at the same time its annual statement is submitted under section 60A.13. The report must also include the number of evaluations performed on behalf of the insurer during the reporting period, the types of evaluations performed, the results, the number of appeals of denials based on these evaluations, the results of these appeals, and the number of complaints filed in a court of competent jurisdiction.

Subd. 8a. **Chemical dependency claim reviewer qualifications.** (a) The personnel file of a chemical dependency claim reviewer must include documentation of the individual's competency in the following areas:

(1) knowledge of chemical abuse and dependency;

(2) chemical use assessment, including client interviewing and screening;

(3) case management, including treatment planning, general knowledge of social services, and appropriate referrals, and record keeping, reporting requirements, and confidentiality rules and regulations that apply to chemical dependency clients; and

(4) individual and group counseling, including crisis intervention.

(b) The insurer may accept one of the following as adequate documentation that a chemical dependency claim reviewer is competent in the areas required under paragraph (a):

(1) the individual has at least a baccalaureate degree with a major or concentration in social work, nursing, sociology, human services, or psychology, is a licensed registered nurse, or is a licensed physician; has successfully completed 30 hours of classroom instruction in each of the areas identified in paragraph (a), clauses (1) and (2); and has successfully completed 480 hours of supervised experience as a chemical dependency counselor, either as a student or as an employee; or

(2) the individual has documented the successful completion of the following:

(i) 60 hours of classroom training in the subject area identified in paragraph (a), clause (1);

(ii) 30 hours of classroom training in the subject area identified in paragraph (a), clause (2);

(iii) 160 hours of classroom training in the subject areas identified in paragraph (a), clauses (3) and (4); and

(iv) completion of 480 hours of supervised experience as a chemical dependency counselor, either as a student or as an employee; or

(3) the individual is certified by the Institute for Chemical Dependency Professionals of Minnesota, Inc., as a chemical dependency counselor or as a chemical dependency counselor reciprocal, through the evaluation process established by the Certification Reciprocity Consortium Alcohol and Other Drug Abuse, Inc., and published in the Case Presentation Method Trainer's Manual, copyright 1986;

(4) the individual successfully completed three years of supervised work experience as a chemical dependency counselor before January 1, 1988; or

(5) the individual is a licensed physician, who has 480 hours of experience in a licensed chemical dependency program.

After January 1, 1993, chemical dependency counselors must document that they meet the requirements of clause (1), (2), or (3) in order to comply with this paragraph.

Subd. 9. **Standards for communications with 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.

For purposes of clause (1) the term insurer includes an agent of the insurer. The insurer must have been sent a copy of any communication to an agent to be held in violation of this provision.

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

Subd. 11. **Disclosure mandatory.** An insurer must disclose the coverage and limits of an insurance policy within 30 days after the information is requested in writing by a claimant.

Subd. 12. **Prejudgment interest.** If a judgment is entered against an insured, the principal amount of which is within the applicable policy limits, the insurer is responsible for their insured's share of the costs, disbursements, and prejudgment interest, as determined under section 549.09, included in the judgment even if the total amount of the judgment is in excess of the applicable policy limits.

Subd. 13. **Improper claim of discount.** (a) No insurer or community integrated service network shall intentionally provide a health care provider with an explanation of benefits or similar document claiming a right to a discounted fee, price, or other charge, when the insurer or community integrated service network does not have an agreement with the provider for the discount with respect to the patient involved.

(b) The insurer or community integrated service network may, notwithstanding paragraph (a), claim the right to a discount based upon a discount agreement between the health care provider and another entity, but only if:

(1) that agreement expressly permitted the entity to assign its right to receive the discount;

(2) an assignment to the insurer or community integrated service network of the right to receive the discount complies with any relevant requirements for assignments contained in the discount agreement; and

(3) the insurer or community integrated service network has complied with any relevant requirements contained in the assignment.

(c) When an explanation of benefits or similar document claims a discount permitted under paragraph (b), it shall prominently state that the discount claimed is based upon an assignment and shall state the name of the entity from whom the assignment was received. This paragraph does not apply if the entity that issues the explanation of benefits or similar document has a provider agreement with the provider.

(d) No insurer or community integrated service network that has entered into an agreement with a health care provider that involves discounted fees, prices, or other charges shall disclose the discounts to another entity, with the knowledge or expectation that the disclosure will result in claims for discounts prohibited under paragraphs (a) and (b).

History: *1984 c 555 s 3; 1987 c 64 s 1; 1989 c 193 s 1; 1989 c 260 s 21–23; 1991 c 115 s 1,2; 1991 c 131 s 2; 1991 c 207 s 7; 1992 c 413 s 1; 1992 c 524 s 2; 1992 c 564 art 1 s 47; art 3 s 27; 1994 c 485 s 56,65; 1995 c 234 art 7 s 27; 1997 c 77 s 4; 1997 c 225 art 2 s 62; 1999 c 239 s 41; 2000 c 342 s 1; 2001 c 117 art 2 s 17; 2002 c 283 s 1; 2005 c 77 s 5; 2005 c 140 s 1; 2006 c 255 s 60*

72A.202 [Repealed, 2002 c 283 s 3]

72A.205 [Repealed, 1996 c 446 art 1 s 72; 1998 c 339 s 72]

72A.206 [Repealed, 1992 c 540 art 2 s 22]

72A.207 GRADED DEATH BENEFITS.

For the purpose of this section, a graded death benefit is a provision within a life insurance policy in which the death benefit, in the early years of the policy, is less than the face amount of the policy, but which increases with the passage of time.

No policy of life insurance paying a graded death benefit may be issued in this state unless the graded death benefit is equal to at least four times the first year premium. This section does not prohibit the return of premiums or premiums plus interest in connection with the voluntary or judicially ordered rescission of the policy, or according to the terms of the exclusions from coverage for suicide, aviation, or war risk.

History: *1996 c 446 art 1 s 66*

72A.21 POWER OF COMMISSIONER.

The commissioner shall have power to examine and investigate into the affairs of every person engaged in the business of insurance in this state in order to determine whether that person has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice prohibited by section 72A.19.

History: *1967 c 395 art 12 s 21*

72A.22 HEARING; WITNESSES; PRODUCTION OF BOOKS.

Subdivision 1. **Statement of charges and notice of hearing.** Whenever the commissioner has reason to believe that any person has been engaged or is engaging in this state in any unfair method of competition or any unfair or deceptive act or practice, defined in section 72A.20, and that a proceeding in respect thereto would be to the interest of the public, the commissioner shall issue and serve upon that person a statement of the charges in that respect and a notice of a hearing thereon to be held at a time and place fixed in the notice, which shall not be less than 20 days after the date of the service thereof.

Subd. 2. **Appearance; intervention.** At the time and place fixed for such hearing said person shall have an opportunity to be heard and to show cause why an order should not be made by the commissioner requiring the person to cease and desist from the acts, methods, or practices so complained of. Upon good cause shown, the commissioner shall permit any person to intervene, appear and be heard at such hearing by counsel or in person.

Subd. 3. **Formal rules of pleading or evidence not required.** Nothing contained in sections 72A.17 to 72A.32 shall require the observance at any such hearing of formal rules of pleading or evidence.

Subd. 4. **Hearing.** The commissioner, upon such a hearing, may administer oaths, examine and cross-examine witnesses, receive oral and documentary evidence, and shall have the power to subpoena witnesses, compel their attendance, and require the production of books, papers, records, correspondence, or other documents which the commissioner deems relevant to the inquiry. The commissioner, upon such a hearing, may, and upon the request of any party shall, cause to be made a stenographic record of all the evidence and all the proceedings had at the hearing. If no stenographic record is made and if a judicial review is sought, the commissioner shall prepare a statement of the evidence and proceeding for use on review. In case of a refusal of any person to comply with any subpoena issued hereunder or to testify with respect to any matter concerning which the person may be lawfully interrogated, the District Court of Ramsey County or of the county where the hearing is being held, on application of the commissioner, may issue an order requiring that person to comply with the subpoena and to testify; and any failure to obey any such order of the court may be punished by the court as a contempt thereof.

Subd. 5. **Service.** Statements of charges, notices, orders, and other processes of the commissioner under sections 72A.17 to 72A.32 may be served by anyone duly authorized by the commissioner, either in the manner provided by law for service of process in civil actions or in compliance with section 45.028, subdivision 2.

History: *1967 c 395 art 12 s 22; 1986 c 444; 1992 c 564 art 2 s 7*

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

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

72A.25 UNFAIR COMPETITION.

Subdivision 1. **Statement of charges; service; hearing.** Whenever the commissioner has reason to believe that any person engaged in the business of insurance is engaged in this state in any method of competition or in any act or practice in the conduct of that business which is not defined in section 72A.20, that said method of competition is unfair or that said act or practice is unfair or deceptive and that a proceeding in respect thereto would be to the interest of the public, the commissioner may issue and serve upon that person a statement of the charges in that respect and a notice of a hearing thereon to be held at a time and place fixed in the notice, which shall not be less than 20 days after the date of the service thereof. Each such hearing shall be conducted in the same manner as the hearings provided for in section 72A.22, and the provisions of that section as to service are made applicable to proceedings under this section. Upon good cause shown, the commissioner shall permit any person to intervene, appear and be heard at such hearing by counsel or in person. The commissioner shall, after the hearing, make a written report which shall include findings as to the facts and shall serve a copy thereof upon the person served with the statement of charges.

Subd. 2. **Application for injunction.** If the report charges a violation of sections 72A.17 to 72A.32 and if the method of competition, act, or practice charged has not been discontinued, the commissioner may, through the attorney general, at any time after 20 days after the service of the report, cause a petition to be filed in the District Court of Ramsey County, to enjoin and restrain that person from engaging in the method, act, or practice charged. A transcript of the proceedings before the commissioner, including all evidence taken and the report and findings, shall be filed with the petition. Upon the filing of the petition and transcript the court shall have jurisdiction of the proceedings and shall have power to make and enter appropriate orders in connection therewith and to issue such writs as are ancillary to its jurisdiction or necessary in its judgment to prevent injury to the public pendente lite.

Subd. 3. **Order enjoining and restraining.** If the court finds that the method of competition complained of is unfair or that the act or practice complained of is unfair and decep-

tive, and that the proceeding by the commissioner with respect thereto is to the interests of the public, it shall issue its order enjoining and restraining the continuance of that method of competition, act, or practice. The findings of the commissioner shall be given the same effect as those of a referee appointed pursuant to rule 53 of the Rules of Civil Procedure.

Subd. 4. **Rehearing.** If either party shall apply to the court before the entry of its order for leave to adduce additional evidence, and shall show to the satisfaction of the court that said additional evidence is material and that there were reasonable grounds for the failure to adduce it in the proceeding before the commissioner, the court may order said additional evidence to be taken before the commissioner and to be adduced upon the hearing in such manner and upon such terms and conditions as to the court may seem proper. The commissioner may modify the findings of fact, or make new findings, by reason of the additional evidence so taken, and shall file those modified or new findings with the return of the additional evidence. Any such additional evidence and modified or new findings shall be considered by the court in making and entering its final order, together with the matters submitted in the original transcript.

History: *1967 c 395 art 12 s 25; 1976 c 239 s 18; 1984 c 555 s 5; 1986 c 444*

72A.26 INTERVENTION.

If the report of the commissioner does not charge a violation of sections 72A.17 to 72A.32, any intervenor in the proceedings may, within 20 days after the service of the report, cause a petition to be filed in the District Court of Ramsey County for a review of that report. Notice of the filing of the intervenor's petition shall be given to the commissioner and to the person upon whom the statement of charges was originally served. The commissioner shall, within 20 days after the service of the notice of filing the petition, file a transcript of the proceedings, including all evidence taken and the report and findings, and the person upon whom the statement of charges was originally served shall have 20 days after the service of notice of filing the petition in which to file an answer. The proceedings before the court shall conform to those provided for by section 72A.25. Upon such a review the court shall have authority to issue appropriate orders and writs in connection therewith, including, if the court finds it is to the interest of the public, orders enjoining and restraining the continuance of any method of competition, act, or practice which it finds, notwithstanding the report of the commissioner, constitutes a violation of sections 72A.17 to 72A.32.

History: *1967 c 395 art 12 s 26; 1986 c 444*

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: *1967 c 395 art 12 s 27; 1983 c 247 s 37; 1987 c 336 s 8*

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

72A.285 CLAIM FOR INSURANCE BENEFITS; RELEASE OF SUMMARY INFORMATION.

Notwithstanding section 145.64, when a review organization, as defined in section 145.61, has conducted a review of health services given or proposed to be given to an insured or claimant in connection with or in anticipation of a claim for insurance benefits, a complete summary of the review findings must be furnished by the insurer to the provider who requested the review or to the insured or claimant, upon that person's request.

The summary must list the qualifications of the reviewer, including any license, certification, or specialty designation. The summary must also describe the relationship between the insured's or claimant's diagnosis and the review criteria used as a basis for the claim decision, including the specific rationale for the reviewer's decision.

Nothing in this section requires the disclosure of the identity of the person conducting the review.

History: *1991 c 264 s 3*

72A.29 CONCURRENT REMEDIES.

Subdivision 1. **Liability under other laws.** No order of the commissioner, or order or decree of any district court, under sections 72A.17 to 72A.32 shall in any way relieve or absolve any person affected by such order or decree from any liability under any other laws of this state.

Subd. 2. **Concurrent powers.** The powers vested in the commissioner by sections 72A.17 to 72A.32 shall be additional to any other powers to enforce any penalties, fines, or forfeitures authorized by law with respect to the methods, acts, and practices hereby declared to be unfair or deceptive.

History: *1967 c 395 art 12 s 29*

72A.30 EVIDENTIAL PRIVILEGE DENIED; IMMUNITY; WAIVER.

A person who asks to be excused from attending and testifying or from producing any books, papers, records, correspondence, or other documents at any hearing on the ground that the testimony or evidence required may tend to incriminate or subject the person to a penalty or forfeiture, who is nevertheless directed to give the testimony or produce the evidence, shall comply with the direction. However, the person shall not subsequently be prosecuted or subjected to any penalty or forfeiture because of any transaction, matter, or thing about which the person testified or produced evidence, and no testimony given or evidence produced shall be received against that person upon any criminal action, investigation, or proceeding. No person testifying is exempt from prosecution or punishment for perjury committed while testifying, and the testimony or evidence given or produced shall be admissible against that person upon any criminal action, investigation, or proceeding concerning the perjury. The person is not exempt from the refusal, revocation, or suspension of any license, permission, or authority conferred, or to be conferred, pursuant to the insurance law of this state.

An individual may execute, acknowledge, and file in the office of the commissioner a statement expressly waiving immunity or privilege in respect to any transaction, matter, or thing specified in the statement, and the testimony of that person or any evidence in relation to it may be received or produced before any judge, court, tribunal, grand jury, or otherwise. When it is received or produced, that individual is not entitled to any immunity or privilege on account of any testimony given or evidence produced by that individual.

History: *1967 c 395 art 12 s 30; 1983 c 359 s 2; 1986 c 444*

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

Subdivision 1. **Real and personal property financing; prohibited acts by businesses.** 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.

Subd. 2. **Public agency construction insurance or bond; prohibited acts.** It shall be unlawful in connection with any contract or subcontract calling for any construction work for a public agency to require, directly or indirectly, that any insurance or bond be purchased or renewed through a particular agent or insurer.

History: *1967 c 395 art 12 s 31; 1969 c 229 s 1; 1969 c 433 s 1; 1983 c 289 s 114 subd 1; 1984 c 655 art 1 s 92; 1986 c 444; 1987 c 337 s 120*

72A.32 VIOLATIONS, PROCEDURE.

Any violation of section 72A.31 shall constitute an unfair method of competition and the person, firm or corporation practicing the same shall be proceeded against under the provisions of sections 72A.21 to 72A.25, inclusive.

History: *1967 c 395 art 12 s 32*

72A.321 [Repealed, 1981 c 129 s 2]

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 persons with legal authority to control the disposition of the remains of the deceased policyholder under section 149A.80, subdivision 2, 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, except the sale of a preneed funeral insurance contract with a face amount not to exceed $20,000.

For purposes of this section, "preneed funeral insurance contract" means an agreement by or for an individual before that individual's death relating to the purchase or provision of specific funeral or cemetery merchandise or services.

Nothing in this section constitutes a waiver or exception to the requirements of chapter 60K.

History: *1981 c 129 s 1; 1987 c 233 s 1; 1999 c 100 s 1*

72A.327 HEALTH CLAIMS; RIGHTS OF APPEAL.

(a) An insured whose claim for medical benefits under chapter 65B is denied because the treatment or services for which the claim is made is claimed to be experimental, investigative, not medically necessary, or otherwise not generally accepted by licensed health care providers and for which the insured has financial responsibility in excess of applicable co–payments and deductibles may appeal the denial to the commissioner.

(b) This section does not apply to claims for health benefits which have been arbitrated under section 65B.525, subdivision 1.

(c) A three–member panel shall review the denial of the claim and report to the commissioner. The commissioner shall establish a list of qualified individuals who are eligible to serve on the panel. In establishing the list, the commissioner shall consult with representatives of the contributing members as defined in section 65B.01, subdivision 2, and professional societies. Each panel must include: one person with medical expertise as identified by the contributing members; one person with medical expertise as identified by the professional societies; and one public member. The commissioner, upon initiation of an arbitration, shall select from each list three potential arbitrators and shall notify the issuer and the claimant of the selection. Each party shall strike one of the potential arbitrators and an arbitrator shall be selected by the commissioner from the remaining names of potential arbitrators if more than one potential arbitrator is left. In the event of multiparty arbitration, the commissioner may increase the number of potential arbitrators and divide the strikes so as to afford an equal number of strikes to each adverse interest. If the selected arbitrator is unable or unwilling to serve for any reason, the commissioner may appoint an arbitrator, which will be subject to challenge only for cause. The party that denied the coverage has the burden of proving that the services or treatment are experimental, investigative, not medically necessary, or not generally accepted by licensed health care professionals. In determining whether the burden has been met, the panel may consider expert testimony, medical literature, and any other relevant sources. If the party fails to sustain its burden, the commissioner may order the immediate payment of the claim. All proceedings of the panel and any documents received or developed by the review process are nonpublic.

(d) A person aggrieved by an order under this section may appeal the order. The appeal shall be pursuant to section 65B.525 where appropriate, or to the district court for a trial de novo, in all other cases. In nonemergency situations, if the insurer has an internal grievance or appeal process, the insured must exhaust that process before the external appeal. In no event shall the internal grievance process exceed the time limits described in section 72A.201, subdivision 4a.

(e) If prior authorization is required before services or treatment can be rendered, an appeal of the denial of prior authorization may be made as provided in this section.

(f) The commissioner shall adopt procedural rules for the conduct of appeals.

(g) The permanent rulemaking authority granted in this section is effective June 2, 1989, regardless of the actual effective date of January 1, 1990.

History: *1989 c 330 s 34*

UNAUTHORIZED INSURERS FALSE ADVERTISING PROCESS

72A.33 PURPOSE OF ACT, CONSTRUCTION.

The purpose of sections 72A.33 to 72A.39 is to subject to the jurisdiction of the commissioner of commerce of this state and to the jurisdiction of the courts of this state insurers

not authorized to transact business in this state which place in or send into this state any false advertising designed to induce residents of this state to purchase insurance from insurers not authorized to transact business in this state. The legislature declares it is in the interest of the citizens of this state who purchase insurance from insurers which solicit insurance business in this state in the manner set forth in the preceding sentence that such insurers be subject to the provisions of sections 72A.33 to 72A.39. In furtherance of such state interest, the legislature herein provides a method of substituted service of process upon such insurers and declares that in so doing, it exercises its power to protect its residents and also exercises powers and privileges available to the state by virtue of Public Law 15, 79th Congress of the United States, chapter 20, 1st Session, section 340, which declares that the business of insurance and every person engaged therein shall be subject to the laws of the several states; the authority provided herein to be in addition to any existing powers of this state. The provisions of sections 72A.33 to 72A.39 shall be liberally construed.

History: *1967 c 395 art 12 s 33; 1983 c 289 s 114 subd 1; 1984 c 655 art 1 s 92*

72A.34 DEFINITIONS.

Subdivision 1. **Scope.** When used in sections 72A.33 to 72A.39 the terms defined in this section shall have the meanings given them in this section.

Subd. 2. **Unfair Trade Practice Act.** "Unfair Trade Practice Act" shall mean the act relating to regulation of trade practices as defined in sections 72A.17 to 72A.32.

Subd. 3. **Residents.** "Residents" shall mean and include persons, partnerships or corporations, domestic, alien, or foreign.

History: *1967 c 395 art 12 s 34*

72A.35 NOTICE TO DOMICILIARY SUPERVISORY OFFICIAL.

No unauthorized foreign or alien insurer of the kind described in section 72A.33 shall make, issue, circulate or cause to be made, issued or circulated, to residents of this state any estimate, illustration, circular, pamphlet, or letter, or cause to be made in any newspaper, magazine or other publication or over any radio or television station, any announcement or statement to such residents misrepresenting its financial condition or the terms of any contracts issued or to be issued or the benefits or advantages promised thereby, or the dividends or share of the surplus to be received thereon in violation of the Unfair Trade Practice Act, and whenever the commissioner shall have reason to believe that any such insurer is engaging in such unlawful advertising, it shall be the commissioner's duty to give notice of such fact by certified mail to such insurer and to the insurance supervisory official of the domiciliary state of such insurer. For the purpose of this section, the domiciliary state of an alien insurer shall be deemed to be the state of entry or the state of the principal office in the United States.

History: *1967 c 395 art 12 s 35; 1978 c 674 s 60; 1986 c 444*

72A.36 ACTION BY COMMISSIONER.

If after 30 days following the giving of the notice mentioned in section 72A.35 such insurer has failed to cease making, issuing, or circulating such false representations or causing the same to be made, issued or circulated in this state, and if the commissioner has reason to believe that a proceeding in respect to such matters would be to the interest of the public, and that such insurer is issuing or delivering contracts of insurance to residents of this state or collecting premiums on such contracts or doing any of the acts enumerated in section 72A.37, the commissioner shall take action against such insurer under the unfair trade practice act.

History: *1967 c 395 art 12 s 36; 1986 c 444*

72A.37 SERVICE UPON UNAUTHORIZED INSURER.

Subdivision 1. **Acts constituting appointment of commissioner as attorney.** Any of the following acts in this state, effected by mail or otherwise, by any such unauthorized for-

eign or alien insurer: (1) The issuance or delivery of contracts of insurance to residents of this state; (2) the solicitation of applications for such contracts; (3) the collection of premiums, membership fees, assessments or other considerations for such contracts; or (4) any other transaction of insurance business; is equivalent to and shall constitute an appointment by such insurer of the commissioner of commerce and a successor or successors in office, to be its true and lawful attorney, upon whom may be served all statements of charges, notices and lawful process in any proceeding instituted in respect to the misrepresentations set forth in section 72A.35 under the provisions of the Unfair Trade Practice Act, or in any action, suit or proceeding for the recovery of any penalty therein provided, and any such act shall be signification of its agreement that such service of statement of charges, notices or process is of the same legal force and validity as personal service of such statement of charges, notices or process in this state, upon such insurer.

Subd. 2. **Method of service.** Service of a statement of charges and notices under said unfair trade practice act shall be made by any deputy or employee of the Department of Commerce upon the commissioner or some person in apparent charge of the office, in compliance with section 45.028. Service of process issued by any court in any action, suit or proceeding to collect any penalty under said act provided, shall be made in compliance with section 45.028, subdivision 2.

Subd. 3. **Service on agents and certain others.** Service of statement of charges, notices and process in any such proceeding, action or suit shall in addition to the manner provided in subdivision 2 be valid if served upon any person within this state who on behalf of such insurer is

(1) soliciting insurance, or

(2) making, issuing or delivering any contract of insurance, or

(3) collecting or receiving in this state any premium for insurance;

and a copy of such statement of charges, notices or process is sent within ten days thereafter by certified mail by or on behalf of the commissioner to the defendant at the last known principal place of business of the defendant, and the defendant's receipt, or the receipt issued by the post office with which the letter is certified, showing the name of the sender of the letter, the name and address of the person to whom the letter is addressed, and the affidavit of the person mailing the same showing a compliance herewith, are filed with the commissioner in the case of any statement of charges or notices, or with the court administrator of the court in which such action is pending in the case of any process, on or before the date the defendant is required to appear or within such further time as the court may allow.

Subd. 4. **Cease or desist order.** No cease or desist order under this section shall be entered until the expiration of 30 days from the date of the filing of the affidavit of compliance.

Subd. 5. **Other methods of service.** Service of process and notice under the provisions of sections 72A.33 to 72A.39 shall be in addition to all other methods of service provided by law, and nothing in sections 72A.33 to 72A.39 shall limit or prohibit the right to serve any statement of charges, notices or process upon any insurer in any other manner now or hereafter permitted by law.

History: *1967 c 395 art 12 s 37; 1978 c 674 s 60; 1983 c 289 s 114 subd 1; 1984 c 655 art 1 s 92; 1986 c 444; 1Sp1986 c 3 art 1 s 82; 1992 c 564 art 2 s 8*

72A.38 CONSTITUTIONALITY.

If any provision of sections 72A.33 to 72A.39 or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or application of sections 72A.33 to 72A.39 which can be given effect without the invalid provision or application, and to this end the provisions of sections 72A.33 to 72A.39 are declared to be severable.

History: *1967 c 395 art 12 s 38*

72A.39 CITATION.

Sections 72A.33 to 72A.39 may be cited as the Unauthorized Insurers False Advertising Process Act.

History: *1967 c 395 art 12 s 39*

REGULATION OF UNAUTHORIZED INSURERS

72A.40 PURPOSE.

The legislature declares that it is a subject of concern that many residents of this state hold policies of insurance issued or delivered in this state by insurers not authorized to do insurance business in this state. The legislature further declares that it desires to protect residents of this state against acts by insurers not authorized to do an insurance business in this state, to maintain fair and honest insurance markets, to protect the premium tax revenues of this state, to protect authorized insurers who are subject to strict regulation from unfair competition by unauthorized insurers, and to protect against the evasion of the insurance regulatory laws of this state. In furtherance of the state interest, the legislature herein provides a method for substituted service of process upon unauthorized insurers. The legislature declares that in so doing it exercises its power to protect residents of this state and to define what constitutes doing an insurance business in this state, and also exercises powers and privileges available to this state by virtue of Public Law 79–15, Statutes at Large, volume 59, page 33, as amended, which declares that the business of insurance and every person engaged therein shall be subject to the laws of the several states.

History: *1967 c 590 s 1*

72A.41 TRANSACTING BUSINESS WITHOUT CERTIFICATE OF AUTHORITY.

Subdivision 1. **Prohibition; exception.** 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 a policy of insurance or annuity issued prior to July 1, 1967;

(e) contract of insurance procured under the authority of section 60A.19, subdivision 8; or

(f) transactions in this state involving contracts of insurance covering property or risks not located in this state.

Subd. 2. **Acts constituting.** Any of the following acts in this state, effected by mail or otherwise by an unauthorized insurer, shall be included among those deemed to constitute transacting insurance business in this state: (a) the issuance or delivery of a contract of insurance or annuity to a resident of this state; (b) the solicitation of an application for such a contract; (c) the collection of a premium, membership fee, assessment or other consideration for such a contract; or (d) the transaction of any matter subsequent to the execution of such a contract and arising out of it.

Subd. 3. **Failure to obtain certificate.** The failure of a company to obtain a certificate of authority shall not impair the validity of any act or contract of such company and shall not prevent such company from defending any action in any court of this state, but no company

transacting insurance business in this state without a certificate of authority shall be permitted to maintain an action in any court of this state to enforce any right, claim or demand arising out of the transaction of such business until such company shall have obtained a certificate of authority. Nor shall an action be maintained in any court of this state by any successor or assignee of such company on any such right, claim or demand originally held by such company until a certificate of authority shall have been obtained by such company or by a company which has acquired all or substantially all of its assets.

History: *1967 c 590 s 2; 1969 c 6 s 17; 1980 c 436 s 3; 1987 c 384 art 2 s 15; 1994 c 485 s 57*

72A.42 ENFORCEMENT AUTHORITY.

Subdivision 1. **Injunctions.** Whenever the commissioner believes, from evidence satisfactory to the commissioner, that any company is violating or about to violate the provisions of section 72A.41, the commissioner may, through the attorney general of this state, cause a complaint to be filed in the District Court of Ramsey County to enjoin and restrain such company from continuing such violation or engaging therein or doing any act in furtherance thereof. The court shall have jurisdiction of the proceeding and shall have the power to make and enter an order or judgment awarding such preliminary or final injunctive relief as in its judgment is proper.

Subd. 2. **Enforcement proceedings.** The attorney general may proceed in the courts of this state or any reciprocal state to enforce an order or decision in any court proceeding or in any administrative proceeding before the commissioner of commerce.

(a) Definition—In this section:

(1) "Reciprocal state" means any state or territory of the United States the laws of which contain procedures substantially similar to those specified in this section for the enforcement of foreign decrees issued by courts located in other states or territories of the United States, against any insurer incorporated or authorized to do business in said state or territory.

(2) "Foreign decree" means any decree or order in equity or in law, including without being limited thereto, final money judgments for penalties and fines of a court located in a "reciprocal state," including a court of the United States located therein, against any insurer incorporated or authorized to do business in this state.

(3) "Qualified party" means a state regulatory agency acting in its capacity to enforce the insurance laws of its state.

(b) List of reciprocal states: The commissioner of commerce of this state shall determine which states and territories qualify as reciprocal states and shall maintain at all times an up–to–date list of such states.

(c) Filing and status of foreign decrees: a copy of any foreign decree authenticated in accordance with the statutes of this state may be filed in the Office of the Court Administrator of District Court of Ramsey County of this state. The court administrator, upon verifying with the commissioner of commerce that the decree or order qualifies as a "foreign decree" shall treat the foreign decree in the same manner as a decree of District Court of Ramsey County of this state. A foreign decree so filed has the same effect and shall be deemed as a decree of District Court of Ramsey County of this state, and is subject to the same procedures, defenses and proceedings for reopening, vacating, or staying as a decree of District Court of Ramsey County of this state and may be enforced or satisfied in like manner.

(d) Notice of filing:

(1) At the time of the filing of the foreign decree, the attorney general shall make and file with the court administrator an affidavit setting forth the name and last known post office address of the defendant.

(2) Promptly upon the filing of the foreign decree and the affidavit, the court administrator shall mail notice of the filing of the foreign decree to the defendant at the address given and to the commissioner of commerce of this state and shall make a note of the mailing in the docket. In addition, the attorney general may mail a notice of the filing of the foreign decree

to the defendant and to the commissioner of commerce of this state and may file proof of mailing with the court administrator. Lack of mailing notice of filing by the court administrator shall not affect the enforcement proceedings if proof of mailing by the attorney general has been filed.

(3) No execution or other process for enforcement of a foreign decree filed hereunder shall issue until 30 days after the date the decree is filed.

(e) Stay:

(1) If the defendant shows the District Court of Ramsey County that an appeal from the foreign decree is pending or will be taken, or that a stay of execution has been granted, the court may stay enforcement of the foreign decree until the appeal is concluded, the time for appeal expires, or the stay of execution expires or is vacated, upon proof that the defendant has furnished the security for the satisfaction of the decree required by the state in which it was rendered.

(2) If the defendant shows the District Court of Ramsey County any ground upon which enforcement of a decree of District Court of Ramsey County of this state would be stayed, the court may stay enforcement of the foreign decree for an appropriate period, upon requiring the same security for satisfaction of the decree which is required in this state.

(f) Fees: Any person filing a foreign decree shall pay to the court administrator as a fee for docketing, transcription or other enforcement proceedings, the amount provided for decrees of the District Court of Ramsey County.

History: *1967 c 590 s 3; 1969 c 459 s 1; 1983 c 289 s 114 subd 1; 1984 c 655 art 1 s 92; 1986 c 444; 1Sp1986 c 3 art 1 s 82*

72A.43 SERVICE OF PROCESS UPON UNAUTHORIZED COMPANY BY COMMISSIONER.

Subdivision 1. **Appointment of agent.** Any act of entering into a contract of insurance or annuity as an insurer or transacting insurance business in this state as set forth in subdivision 2 of section 72A.41, by an unauthorized company is equivalent to and shall constitute an appointment by such company of the commissioner of commerce and a successor or successors in office to be its true and lawful attorney upon whom may be served all lawful process in any action or proceeding against it, arising out of a violation of section 72A.41, and any of such acts shall be a signification of its agreement that any such process against it which is so served shall be of the same legal force and validity as personal service of process in this state upon such company.

Subd. 2. **How made.** Service of such process shall be made in compliance with section 45.028, subdivision 2.

Subd. 3. **Postponement of service.** The court in any action or proceeding in which service is made in the manner provided in subdivision 2 may, in its discretion, order such postponement as may be necessary to afford such company reasonable opportunity to defend such action or proceeding.

Nothing in this section is to be construed to prevent an unauthorized company from filing a motion to quash a writ or to set aside service thereof made in the manner provided in subdivision 2 on the ground that such unauthorized company has not done any of the acts referred to in subdivision 1.

Subd. 4. **Judgment by default.** No judgment by default shall be entered in any such action or proceeding until the expiration of 30 days from the date of the filing of the affidavit of compliance.

Subd. 5. **Affect on other law.** Nothing contained in this section shall limit or affect the right to serve any process, notice or demand required or permitted by law to be served upon any company in any other manner now or hereafter permitted by law.

History: *1967 c 590 s 4; 1978 c 674 s 60; 1984 c 618 s 3,4; 1986 c 444; 1Sp1986 c 3 art 1 s 82; 1992 c 564 art 2 s 9*

72A.44 PENALTY.

Any company that violates subdivision 1 of section 72A.41, shall be required to pay a penalty of not less than $100 nor more than $1,000 for each offense, to be recovered on behalf of the state.

History: *1967 c 590 s 5*

72A.45 [Repealed, 1994 c 485 s 66]

MINNESOTA INSURANCE FAIR INFORMATION REPORTING

72A.49 SHORT TITLE.

Sections 72A.49 to 72A.505 may be cited as the "Minnesota Insurance Fair Information Reporting Act."

History: *1989 c 316 s 2*

72A.491 DEFINITIONS.

Subdivision 1. **Application.** For the purposes of sections 72A.49 to 72A.505, the following terms have the meanings given them.

Subd. 2. **Adverse underwriting decision.** "Adverse underwriting decision" means any of the following actions with respect to insurance transactions involving insurance coverage that is individually underwritten:

(1) denial, in whole or in part, of coverage that was requested in writing to the insurer;

(2) termination or reduction of insurance coverage or policy;

(3) failure of an insurance agent to apply for coverage with a specific insurer that the agent represents and that is specifically requested by an applicant;

(4) placement by an insurer or insurance agent of a risk with a residual market mechanism, an unauthorized insurer, or an insurer that specializes in substandard risks;

(5) charging a higher rate on the basis of information that differs from that which the applicant or policyholder furnished for property or casualty coverage;

(6) an offer to insure at higher than standard rates for life, health, or disability coverage; or

(7) the rescission of a policy.

Subd. 3. **Affiliate or affiliated.** "Affiliate" or "affiliated" means a person who directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with another person.

Subd. 4. **Applicant.** "Applicant" means any person who seeks to contract for insurance coverage from an insurer.

Subd. 5. **Consumer report.** "Consumer report" means any written, oral, or other communication of information bearing on a person's credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living that is used or expected to be used in connection with an insurance transaction.

Subd. 6. **Consumer reporting agency.** "Consumer reporting agency" means any person who:

(1) regularly engages, in whole or in part, in the practice of assembling or preparing consumer reports for a monetary fee;

(2) obtains information primarily from sources other than insurers; and

(3) furnishes consumer reports to other persons.

Subd. 7. **Control; controlled by; under common control with.** "Control," "controlled by," or "under common control with" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or

nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person.

Subd. 8. **Health care institution.** "Health care institution" means any facility or institution that is licensed to provide health care services to natural persons.

Subd. 9. **Health professional.** "Health professional" means any person licensed or certified to provide health care services to natural persons.

Subd. 10. **Health record information.** "Health record information" means personal information that:

(1) relates to an individual's physical or mental condition, health history, or health treatment; and

(2) is obtained from a health professional or health care institution, from the individual, or from the individual's spouse, parent, legal guardian, or other person.

Subd. 11. **Individual.** "Individual" means any natural person who:

(1) in the case of property or casualty insurance is a past, present, or proposed named insured or certificate holder;

(2) in the case of life, health, or disability insurance is a past, present, or proposed principal insured or certificate holder;

(3) is a past, present, or proposed policy owner;

(4) is a past or present applicant;

(5) is a past or present claimant; or

(6) derived, derives, or is proposed to derive insurance coverage under an insurance policy or certificate subject to this act.

Subd. 12. **Insurance–support organization.** (a) "Insurance–support organization" means any person who regularly engages, in whole or in part, in the practice of assembling or collecting information about persons for the primary purpose of providing the information to an insurer or insurance agent for insurance transactions, including:

(1) the furnishing of consumer reports or investigative consumer reports to an insurer or insurance agent for use in connection with an insurance transaction; and

(2) the collection of personal information from insurers, insurance agents, or other insurance–support organizations to detect or prevent fraud, material misrepresentation, or material nondisclosure in connection with insurance underwriting or insurance claim activity.

(b) Insurance–support organizations do not include insurance agents, government institutions, insurers, health care institutions, or health professionals.

Subd. 13. **Insurance transaction.** "Insurance transaction" means any transaction that involves:

(1) the determination of an individual's eligibility for an insurance coverage, benefit, or payment; or

(2) the servicing of an insurance application, policy, contract, or certificate.

Subd. 14. **Insurer.** "Insurer" means any insurance company, risk retention group as defined under section 60E.02, service plan corporation as defined under section 62C.02, health maintenance organization as defined under section 62D.02, fraternal benefit society regulated under chapter 64B, township mutual company regulated under chapter 67A, joint self–insurance plan or multiple employer trust regulated under chapter 60F, 62H, or section 471.617, subdivision 2, and persons administering a self–insurance plan as defined under section 60A.23, subdivision 8, paragraph (2), clauses (a) and (d).

Subd. 15. **Insurer that specializes in substandard risks.** "Insurer that specializes in substandard risks" means an insurer whose rates and market orientation are directed at risks other than preferred or standard risks.

Subd. 16. **Investigative consumer report.** "Investigative consumer report" means all or part of a consumer report in which information about a person's character, general reputation, personal characteristics, or mode of living is obtained through personal interviews with

the person's neighbors, friends, associates, acquaintances, or others who may have knowledge concerning these items of information.

Subd. 17. **Personal information.** "Personal information" means any individually identifiable information gathered in connection with an insurance transaction from which judgments can be made about an individual's character, habits, avocations, finances, occupation, general reputation, credit, health, or any other personal characteristics. The term includes the individual's name and address and health record information, but does not include privileged information. Personal information does not include health record information maintained by a health maintenance organization as defined under section 62D.02, subdivision 4, in its capacity as a health provider.

Subd. 18. **Policyholder.** "Policyholder" means any individual who is a present named insured, a present policyowner, or a present group certificate holder.

Subd. 19. **Privileged information.** (a) "Privileged information" means any individually identifiable information that:

(1) relates to a claim for insurance benefits or a civil or criminal proceeding; or

(2) is collected in connection with or in reasonable anticipation of a claim for insurance benefits or civil or criminal proceeding.

(b) Information otherwise meeting the definition of privileged information under paragraph (a) must be considered personal information if it is disclosed in violation of section 72A.502.

Subd. 20. **Residual market mechanism.** "Residual market mechanism" means an association, organization, or other entity created under the laws of this state to provide insurance coverage to any person who is unable to obtain coverage through ordinary methods in the normal insurance markets.

Subd. 21. **Termination of insurance coverage or termination of an insurance policy.** "Termination of insurance coverage" or "termination of an insurance policy" means either a cancellation or nonrenewal of an insurance policy, in whole or in part, for any reason other than the failure to pay a premium as required by the policy.

Subd. 22. **Unauthorized insurer.** "Unauthorized insurer" means an insurance company that has not been granted a certificate of authority by the commissioner to transact the business of insurance in this state.

History: *1989 c 316 s 3; 2000 c 468 s 20*

72A.492 SCOPE.

Subdivision 1. **Covered policies.** The obligations imposed by sections 72A.49 to 72A.505 apply to insurers, insurance agents, and insurance-support organizations that:

(1) collect, receive, or maintain information in connection with insurance transactions that pertains to persons who are residents of this state; or

(2) engage in insurance transactions with applicants, individuals, or policyholders who are residents of this state.

Subd. 2. **Covered persons.** The rights granted by sections 72A.49 to 72A.505 extend to:

(1) a person who is a resident of this state and is the subject of information collected, received, or maintained in connection with an insurance transaction; and

(2) a person who is a resident of this state and engages in or seeks to engage in an insurance transaction.

Subd. 3. **Exceptions.** (a) Sections 72A.49 to 72A.505 do not apply to information collected from the public records of a governmental authority and maintained by an insurance company or its representatives to insure the title to real property located in this state.

(b) Nothing in sections 72A.49 to 72A.505 gives a patient access to the health records pertaining to the patient maintained by the patient's health provider, or gives the patient the right to alter or amend those health records, unless otherwise provided by law.

(c) Sections 72A.49 to 72A.505 do not apply to any insurance transactions involving property and casualty insurance primarily for business or professional needs.

History: *1989 c 316 s 4*

72A.493 OBTAINING INFORMATION BY IMPROPER MEANS.

An insurer, insurance agent, or insurance–support organization must not obtain information or authorize another person to obtain information in connection with an insurance transaction by:

(1) pretending to be someone else;

(2) pretending to represent a person;

(3) misrepresenting the true purpose of the interview; or

(4) refusing to provide identification upon request.

History: *1986 c 444; 1989 c 316 s 5*

72A.494 NOTICE.

Subdivision 1. **Required.** Each insurer or insurance agent shall provide a notice relating to information practices to each applicant or policyholder in the manner and at the time required by this section.

Subd. 2. **Exemption.** A notice is not required to be provided under this section for:

(1) a group policy or contract that is not individually underwritten; or

(2) a renewal, reinstatement, or a change in benefits for a policy or contract if no personal information is to be collected other than from the applicant or policyholder, or from public records.

Subd. 3. **Timing.** (a) In the case of an application for insurance coverage, the notice must be provided to the applicant or policyholder no later than the time application is made for the coverage, renewal, reinstatement, or change in benefits.

(b) If personal information is to be collected only from the applicant or from public records, the notice may be provided at the time of delivery of the policy or the certificate.

Subd. 4. **Content of notice.** The notice required by this section must be in writing and state:

(1) whether personal information may be collected from persons other than the individual or individuals proposed for coverage;

(2) the types of personal information that may be collected and the types of sources and investigative techniques that may be used to collect the information;

(3) the types of disclosures of personal information that may be made under section 72A.501 and the circumstances under which the disclosures may be made without prior authorization; except that only those circumstances which occur with such frequency as to indicate a general business practice must be described;

(4) a description of the rights established under sections 72A.497 and 72A.498 and the manner in which those rights may be exercised; and

(5) that information obtained from a report prepared by an insurance–support organization may be retained by the insurance–support organization and disclosed to other persons.

Subd. 5. **Abbreviated notice.** In lieu of the notice required under subdivision 4, the insurer or insurance agent may provide an abbreviated notice informing the applicant or policyholder that:

(1) personal information may be collected from persons other than the person or persons proposed for coverage;

(2) the information collected by the insurer or insurance agent may in certain circumstances be disclosed to third parties without authorization;

(3) the person has a right to see their personal records and correct personal information collected; and

(4) the person will be furnished the detailed notice required under subdivision 4 upon request.

Subd. 6. **Other companies or agencies acting on its behalf.** The obligations imposed by this section upon an insurer or insurance agent may be satisfied by another insurer or insurance agent authorized to act on its behalf.

History: *1989 c 316 s 6*

72A.495 MARKETING AND RESEARCH SURVEYS.

An insurer or insurance agent shall clearly specify any questions designed to obtain information solely for marketing or research purposes from an individual in connection with an insurance transaction, and state that responses to the questions are not required to obtain coverage.

History: *1989 c 316 s 7*

72A.496 INVESTIGATIVE CONSUMER REPORTS.

Subdivision 1. **Notice.** An insurer, insurance agent, or insurance–support organization must not prepare or request an investigative consumer report about an individual in connection with an insurance transaction involving an application for insurance, a policy renewal, a policy reinstatement, or a change in insurance benefits, unless the insurer or insurance agent informs the person:

(1) that the individual may request to be interviewed in connection with the preparation of the investigative consumer report; and

(2) that, upon a request pursuant to section 72A.497, the individual is entitled to receive a copy of the investigative consumer report.

Subd. 2. **Reports prepared by insurers.** If an investigative consumer report is to be prepared by an insurer or insurance agent, the insurer or insurance agent shall institute reasonable procedures to conduct a personal interview requested by an individual.

Subd. 3. **Reports prepared by insurance–support organizations.** If an investigative consumer report is to be prepared by an insurance–support organization, the insurer or insurance agent desiring the report shall inform the insurance–support organization whether a personal interview has been requested by the individual. The insurance–support organization shall institute reasonable procedures for conducting an interview, if requested.

History: *1989 c 316 s 8*

72A.497 ACCESS TO PERSONAL INFORMATION.

Subdivision 1. **Request.** (a) If an individual, after proper identification, submits a written request to an insurer, insurance agent, or insurance–support organization for access to personal information about the individual, the insurer, insurance agent, or insurance–support organization shall within 30 business days from the date the request is received:

(1) inform the individual of the nature and substance of the personal information that they possess in writing, by telephone, or by other oral communication, whichever the insurer, insurance agent, or insurance–support organization elects;

(2) permit the individual to see and copy, in person, the personal information pertaining to that person;

(3) permit the individual to obtain by mail a copy of all of the personal information or a reasonably described portion thereof, whichever the individual requests;

(4) disclose to the individual the identity of those persons to whom the insurer, insurance agent, or insurance–support organization has disclosed the personal information within two years before the request; and

(5) provide the individual with a summary of the procedures by which the person may request correction, amendment, or deletion of personal information, as provided under section 72A.498.

(b) If the personal information is in coded form, an accurate translation in plain language must be provided in writing.

(c) If credit information is requested that federal law prohibits an insurer to disclose, the insurer must disclose that the individual has the right to receive the credit information from the credit reporting agency. The insurer must disclose the name, address, and telephone number of the credit reporting agency that supplied the insurer with the credit information.

Subd. 2. **Source.** Any personal information collected must specifically identify the source of the information.

Subd. 3. **Health records.** (a) Health record information requested under subdivision 1 that has been supplied by a health care institution or a health professional must provide the identity of the health professional or health care institution that supplied the information. The health record information must be provided either directly to the individual or to a health professional designated by the person who is licensed to provide health care with respect to the condition to which the information relates, whichever the individual elects. If the information is provided to a designated health professional, the insurer, insurance agent, or insurance–support organization shall notify the person, at the time of the disclosure, that the information has been provided to the health professional.

(b) If a health professional or a health care institution has provided health information to an insurer, insurance–support organization, or insurance agent that the health professional or health care institution has determined and indicates in writing that the release of the health record information is detrimental to the physical or mental health of the person, or is likely to cause the individual to inflict self–harm or to harm another, the insurer, insurance agent, or insurance–support organization may provide that information directly to the individual only with the approval of the health professional with treatment responsibility for the condition to which the information relates. If approval is not obtained, the information must be provided to the health professional designated by the individual.

(c) Nothing in this section may reduce or affect a patient's rights under section 144.335.

Subd. 4. **Fee.** An insurer, insurance agent, or insurance–support organization may charge a reasonable fee, not to exceed the actual costs, to copy information provided under this section. If an individual is requesting information as a result of an adverse underwriting decision, the insurer, insurance agent, or insurance–support organization must provide the information free of any charge.

Subd. 5. **Other companies or agents acting on its behalf.** The obligations imposed by this section upon an insurer or insurance agent may be satisfied by another insurer or insurance agent authorized to act on its behalf. With respect to the copying and disclosure of personal information under a request under subdivision 1, an insurer, insurance agent, or insurance–support organization may make arrangements with an insurance–support organization or a consumer reporting agency to copy and disclose personal information on its behalf.

Subd. 6. **Privileged information.** The rights granted under this section and section 72A.498 do not extend to privileged information.

History: *1989 c 316 s 9*

72A.498 CORRECTION, AMENDMENT, OR DELETION OF PERSONAL INFORMATION.

Subdivision 1. **Procedure.** Within 30 business days from the date of receipt of a written request from an individual to correct, amend, or delete any personal information about the person within its possession, an insurer, insurance agent, or insurance–support organization shall either:

(1) correct, amend, or delete the portion of the personal information in dispute; or

(2) notify the individual of its refusal to make the correction, amendment, or deletion, the reasons for the refusal, and the person's right to file a statement as provided in subdivision 3, and the individual's right to appeal to the commissioner under subdivision 5.

Subd. 2. **Notice.** If the insurer, insurance agent, or insurance–support organization corrects, amends, or deletes disputed personal information upon request of an individual or as

ordered by the commissioner, the insurer, insurance agent, or insurance–support organization shall notify the person in writing and provide the correction, amendment, or fact of deletion to:

(1) any person specifically designated by the individual who may have within the preceding two years received the personal information;

(2) any insurance–support organization whose primary source of personal information is insurers, if the insurance–support organization has systematically received the personal information from the insurer within the preceding seven years, provided that the correction, amendment, or fact of deletion need not be provided to an insurance–support organization if the insurance–support organization no longer maintains personal information about the individual; and

(3) any insurance–support organization that provided the personal information that has been corrected, amended, or deleted.

Subd. 3. **Statement.** If the insurer, insurance agent, or insurance–support organization refuses to correct, amend, or delete disputed personal information, the individual must be permitted to file with the insurer, insurance agent, or insurance–support organization a concise statement setting forth what the person thinks is the correct, relevant, or fair information and stating the reasons why the individual disagrees with the insurer's, insurance agent's, or insurance–support organization's refusal to correct, amend, or delete disputed personal information.

Subd. 4. **Disputed information.** In the event an individual files a statement described in subdivision 3, the insurer, insurance agent, or insurance–support organization shall:

(1) file the statement with the disputed personal information and provide a means by which anyone reviewing the disputed personal information will be made aware of the individual's statement and have access to it;

(2) in any subsequent disclosure by the insurer, insurance agent, or insurance–support organization of the disputed personal information, clearly identify the matter or matters in dispute and provide the individual's statement along with the personal information being disclosed; and

(3) furnish the statement to the persons and in the manner specified in subdivision 2.

Subd. 5. **Appeal.** (a) If an insurer, insurance–support organization, or insurance agent refuses to correct, amend, or delete disputed personal information, the individual may file an appeal with the commissioner.

(b) The commissioner may, after providing the insurer, insurance–support organization, or insurance agent an opportunity for a hearing, order the insurer, insurance–support organization, or insurance agent to amend, correct, or delete disputed personal information if the commissioner finds that the personal information kept by the insurer, insurance–support organization, or insurance agent is in error. If the commissioner finds that the disputed personal information maintained by the insurer, insurance agent, or insurance–support organization is correct, the insurer, insurance agent, or insurance–support organization may delete from the individual's records any statement filed with them by that individual relating to the disputed information under subdivision 3.

History: *1989 c 316 s 10*

72A.499 REASONS FOR ADVERSE UNDERWRITING DECISIONS.

Subdivision 1. **Notice and information.** (a) In the event of an adverse underwriting decision, the insurer or insurance agent responsible for the decision shall provide in writing to the applicant, policyholder, or individual proposed for coverage:

(1) the specific reason or reasons for the adverse underwriting decision, a summary of the person's rights under sections 72A.497 and 72A.498, and that upon request the person may receive the specific items of personal information that support those reasons and the specific sources of the information; or

(2) the specific reason or reasons for the adverse underwriting decision, the specific items of personal and privileged information that support those reasons, the names and addresses of the sources that supplied the specific items of information specified, and a summary of the rights established under sections 72A.497 and 72A.498.

(b) In addition to the requirements of paragraph (a), if the adverse underwriting decision is either solely or partially based upon a report of creditworthiness, credit standing, or credit capacity that an insurer receives from a consumer reporting agency, the insurer or insurance agent responsible for the decision shall provide in writing to the applicant, policyholder, or individual proposed for coverage the primary reason or reasons for the credit score or other credit based information used by the insurer in the insurer's adverse underwriting decision.

Subd. 2. **Health reasons.** If the specific reason for an adverse underwriting decision is based on health record information, the insurer may, in lieu of providing the specific reason to the individual under subdivision 1, provide the individual with the specific source of the adverse underwriting decision referring to the specific date, page, and line of the information received from a health professional or health care institution. If the insured has been informed of the condition indicated by their health provider and is unable to determine the reason for the adverse underwriting decision, then the insurer must provide the specific reason to the individual. The insurer must provide the specific reason for the adverse underwriting decision to a health professional designated by the individual, if requested either orally or in writing by the individual.

Subd. 3. **Exemption.** (a) This section is not applicable to group policies or contracts, except for group policies that are individually underwritten. For group policies or contracts that are individually underwritten, the notice required under this section must be given to the individual or individuals in the group whose personal information resulted in the adverse underwriting decision.

(b) If a policy or contract is terminated on a class or statewide basis, or an insurance coverage is declined solely because the coverage is unavailable on a class or statewide basis, the insurer or agent is not required to provide the notice required under this section provided that the applicant or policyholder is provided with the specific reason for the termination or declination of coverage.

Subd. 4. **Privileged information.** (a) An insurer or insurance agent is not required to provide particular, specific items of privileged information under subdivision 1 if it has a reasonable suspicion, based upon that specific information, that the applicant, policyholder, or person proposed for coverage has engaged in criminal activity, fraud, material misrepresentation, or material nondisclosure. If an insurer or insurance agent does not provide the specific items of information because the information is privileged under this subdivision, the insurer or insurance agent must notify the applicant, policyholder, or individual proposed for coverage that the specific items of information are privileged and of the person's right to appeal to the commissioner under this subdivision.

(b) If a person is not provided with the specific items of information relating to an adverse underwriting decision because the information is privileged under this subdivision, the person may request that the commissioner review the information. The commissioner may then order the insurer or insurance agent to supply the privileged information to the commissioner. If the commissioner determines that the information is not privileged under this subdivision, the commissioner shall order the insurer or insurance agent to provide the information to the applicant, policyholder, or person proposed for coverage.

Subd. 5. **Health records information.** Specific items of health record information supplied by a health care institution or health professional, and the identity of the health professional or health care institution that supplied the information, must be disclosed in the manner required under section 72A.497, subdivision 3.

Subd. 6. **Other companies or agents acting on its behalf.** The obligations imposed by this section upon an insurer or insurance agent may be satisfied by another insurer or insurance agent authorized to act on its behalf.

History: *1989 c 316 s 11; 2000 c 483 s 23*

72A.50 PREVIOUS ADVERSE UNDERWRITING DECISIONS.

Subdivision 1. **Additional information required.** An insurer, insurance agent, or insurance–support organization must not seek information in connection with an insurance transaction concerning any previous adverse underwriting decision experienced by a person, or any previous insurance coverage obtained by a person through a residual market mechanism, unless the inquiry also requests the reasons for the previous adverse underwriting decision or the reasons why insurance coverage was previously obtained through a residual market mechanism.

Subd. 2. **Prohibitions.** An insurer or insurance agent may not base an adverse underwriting decision, in whole or in part, on:

(1) the fact of a previous adverse underwriting decision or the fact that a person previously obtained insurance coverage through a residual market mechanism, provided that an insurer or insurance agent may base an adverse underwriting decision on further information obtained from an insurer or insurance agent responsible for a previous adverse underwriting decision; or

(2) personal information received from an insurance–support organization whose primary source of information is insurers, provided that an insurer or insurance agent may base an adverse underwriting decision on further personal information obtained as the result of information received from the insurance–support organization.

History: *1989 c 316 s 12*

72A.501 DISCLOSURE AUTHORIZATION.

Subdivision 1. **Requirement; content.** An authorization used by an insurer, insurance–support organization, or insurance agent to disclose or collect personal or privileged information must be in writing and must meet the following requirements:

(1) is written in plain language;

(2) is dated;

(3) specifies the types of persons authorized to disclose information about the person;

(4) specifies the nature of the information authorized to be disclosed;

(5) names the insurer or insurance agent and identifies by generic reference representatives of the insurer to whom the person is authorizing information to be disclosed;

(6) specifies the purposes for which the information is collected; and

(7) specifies the length of time the authorization remains valid.

If the insurer, insurance–support organization, or insurance agent determines to disclose or collect a kind of information not specified in a previous authorization, a new authorization specifying that kind of information must be obtained.

Subd. 2. **Application.** (a) If the authorization is signed to collect information in connection with an application for a property and casualty insurance policy, a policy reinstatement, or a request for a change in benefits, the authorization is valid as long as the individual is continually insured with the insurer. At each renewal of the policy, the insurer must notify the insured in writing of the contents of the authorization and that the authorization remains in effect unless revoked.

(b) If the authorization is signed to collect information in connection with an application for a life, disability, and health insurance policy or contract, reinstatement, or request for change in benefits, the authorization is valid as long as the individual is continually insured with the insurer. At each renewal of the policy, the insurer must notify the insured in writing of the contents of the authorization and that the authorization remains in effect unless revoked.

(c) This section and section 72A.502, subdivisions 1 and 12, do not apply to the collection and use of a numeric product referred to as an insurance score or credit score that is used by a licensed insurance agent or insurer exclusively for the purpose of underwriting or rating an insurance policy, if the agent or insurer informs the policyholder or prospective policyholder requesting the insurance coverage that an insurance score or credit score will be obtained for the purpose of underwriting or rating the policy.

Subd. 3. **Claims.** If the authorization is signed to collect information in connection with a claim for benefits under an insurance policy, the authorization must not remain valid for longer than:

(1) the term of coverage of the policy, if the claim is for a health insurance benefit; or

(2) the duration of the claim, if the claim is for a claim other than for a health insurance benefit.

Subd. 4. **Authorization; noninsurers.** If an authorization is submitted to an insurer, insurance–support organization, or insurance agent by a person other than an insurer, insurance–support organization, or insurance agent, the authorization must be dated, signed by the person, and obtained one year or less before the date a disclosure is sought.

History: *1989 c 316 s 13; 1990 c 467 s 2; 2003 c 74 s 10; 2005 c 74 s 11,12*

72A.502 DISCLOSURE OF INFORMATION; LIMITATIONS AND CONDITIONS.

Subdivision 1. **Requirement.** An insurer, insurance agent, or insurance–support organization must not disclose any personal or privileged information about a person collected or received in connection with an insurance transaction without the written authorization of that person except as authorized by this section. An insurer, insurance agent, or insurance–support organization must not collect personal information about a policyholder or an applicant not relating to a claim from sources other than public records without a written authorization from the person.

Subd. 2. **Prevention of fraud.** Personal or privileged information may be disclosed without a written authorization to another person if the information is limited to that which is reasonably necessary to detect or prevent criminal activity, fraud, material misrepresentation, or material nondisclosure in connection with an insurance transaction, and that person agrees not to disclose the information further without the individual written authorization unless the further disclosure is otherwise permitted by this section if made by an insurer, insurance agent, or insurance–support organization.

Subd. 3. **Health care institutions and professionals.** Personal or privileged information may be disclosed without a written authorization to a health care institution or health professional for the purpose of verifying insurance coverage benefits, informing a person of a health problem of which the person must not be aware, or conducting an operations or services audit, if the information is only disclosed that is reasonably necessary to accomplish the purposes under this subdivision.

Subd. 4. **Regulatory authority.** Personal or privileged information may be disclosed without a written authorization to an insurance regulatory authority.

Subd. 5. **Other governmental authorities.** Personal or privileged information may be disclosed without a written authorization to a law enforcement or other governmental authority if:

(1) the disclosure is to protect the interests of the insurer, agent, or insurance–support organization in preventing or prosecuting the perpetration of fraud upon it; or

(2) the insurer, agent, or insurance–support organization reasonably believes that illegal activities have been conducted by the individual.

Subd. 6. **Other laws or order.** Personal or privileged information may be disclosed without a written authorization if permitted or required by another law or in response to a facially valid administrative or judicial order, including a search warrant or subpoena.

Subd. 7. **Actuarial and research studies.** Personal or privileged information may be disclosed without a written authorization to conduct actuarial or research studies if:

(1) no individual may be identified in the actuarial or research report;

(2) materials allowing an individual to be identified are returned or destroyed as soon as they are no longer needed; and

(3) the actuarial or research organization agrees not to disclose the information unless the disclosure would otherwise be permitted by this section if made by an insurance company, agent, or insurance–support organization.

Subd. 8. **Affiliate companies.** Personal or privileged information may be disclosed without a written authorization to an affiliate whose only use of the information will be in connection with an audit of the insurer or agent or the marketing of an insurance product or service, provided the affiliate agrees to not disclose the information for any other purpose or to unaffiliated persons.

Subd. 9. **Group policyholder.** Personal or privileged information may be disclosed without written authorization to a group policyholder only to report claims experience or conduct an audit of the insurer's or agent's operations or services, if the information disclosed is reasonably necessary for the group policyholder to conduct the review or audit.

Subd. 10. **Governmental licensing board.** Personal or privileged information may be disclosed without a written authorization to a governmental professional licensing or regulatory board to review the service or conduct of a health care institution or health professional that the insurer has reason to believe has violated its licensing act or engaged in the unlawful practice of a licensed professional.

Subd. 11. **Professional peer review.** Subject to the terms of a contract between an insurer and a health professional or health care institution, personal or privileged information may be disclosed without a written authorization to a professional peer review organization to review the service or conduct of a health care institution or health professional.

Subd. 11a. **Merger or sale.** Personal or privileged information may be disclosed to a party or representative of a party to a proposed or consummated sale, transfer, merger, or consolidation of all or part of the business of the insurer, agent, or insurance–support organization, without a written authorization provided:

(1) prior to the consummation of the sale, transfer, merger, or consolidation, only such information is disclosed as is reasonably necessary to enable the recipient to make business decisions about the merger, transfer, purchase, or consolidation; and

(2) the recipient agrees not to disclose the information unless the disclosure would otherwise be permitted by this section if made by an insurer, agent, or insurance–support organization.

Subd. 12. **Notice.** Whenever an insurer, insurance agent, or insurance–support organization discloses personal or privileged information about a person that requires the written authorization of that person under this section, the insurer, insurance agent, or insurance–support organization shall notify that person in writing within ten days of the date the information was disclosed. The notification must specify the identity of the person to whom information was disclosed and the nature and substance of the information that was disclosed. A notice is not required to be given under this subdivision if an insurer is disclosing personal information for underwriting purposes to another insurer, or to an insurance–support organization if the person had signed an authorization authorizing the disclosure.

History: *1989 c 316 s 14; 1990 c 467 s 3,4*

72A.503 PRIVATE REMEDIES.

Subdivision 1. **Liability.** Any insurer, insurance agent, or insurance–support organization that violates sections 72A.49 to 72A.505 is liable to the aggrieved person for that violation to the same extent as civil remedies are otherwise allowed in section 13.08, subdivision 1, for violations of chapter 13, by a political subdivision, responsible authority, statewide system, or statewide agency.

Subd. 2. **Equitable relief.** Upon application by an aggrieved person, a court of competent jurisdiction may grant equitable and declaratory relief as necessary to enforce the requirements of sections 72A.49 to 72A.505.

History: *1989 c 316 s 15*

72A.504 OBTAINING INFORMATION UNDER IMPROPER MEANS.

Any person who knowingly and willfully obtains information about a person in violation of section 72A.493 is subject to a fine not to exceed $3,000 or imprisonment not to exceed one year, or both.

History: *1989 c 316 s 16*

72A.505 IMMUNITY.

No cause of action in the nature of defamation, invasion of privacy, or negligence may arise against an insurer, insurance agent, or insurance-support organization for disclosing personal or privileged information required to be disclosed under sections 72A.20, subdivision 11, and 72A.49 to 72A.504, provided no immunity exists for disclosing false information with malice or willful intent to injure any person.

History: *1989 c 316 s 17*

CANCELLATION OF POLICIES

72A.51 RIGHT TO CANCEL.

Subdivision 1. **Date of purchase defined.** For the purposes of this section and section 72A.52 "date of purchase" means the date on which the purchaser receives a copy of the policy or contract.

Subd. 2. **Return of policy or contract; notice.** Any individual person may cancel an individual policy of insurance against loss or damage by reason of the sickness of the assured or the assured's dependents, a nonprofit health service plan contract providing benefits for hospital, surgical and medical care, a health maintenance organization subscriber contract, or a policy of insurance authorized by section 60A.06, subdivision 1, clause (4), by returning the policy or contract and by giving written notice of cancellation any time before midnight of the tenth day following the date of purchase. Notice of cancellation may be given personally, by mail, or by telegram. The policy or contract may be returned personally or by mail. If by mail, the notice or return of the policy or contract is effective upon being postmarked, properly addressed and postage prepaid.

Subd. 3. **Refund of consideration.** With the exception of a variable annuity contract issued pursuant to sections 61A.13 to 61A.21, a person's cancellation of an insurance policy or contract under this section and section 72A.52 is without liability and the person is entitled to a refund of the entire consideration paid for the policy or contract within ten days after notice of cancellation and the returned policy or contract are received by the insurer or its agent. Cancellation under this section and section 72A.52 of a variable annuity contract issued pursuant to sections 61A.13 to 61A.21 shall entitle a person to an amount equal to the sum of (a) the difference between the premiums paid including any contract fees or other charges and the amounts allocated to any separate accounts under the contract and (b) the cash value of the contract, or, if the contract does not have a cash value, the reserve for the contract, on the date the returned contract is received by the insurer or its agent. Cancellation of an insurance policy or contract under this section or section 72A.52 makes the policy or contract void from its inception.

Subd. 4. **Waiver or surrender prohibited.** A person may not waive or surrender a right to cancel an insurance policy or contract under this section and section 72A.52.

History: *1977 c 178 s 1; 1980 c 354 s 1; 1986 c 444*

72A.52 NOTICE REQUIREMENTS.

Subdivision 1. **Contents.** In addition to all other legal requirements a policy or contract of insurance described in section 72A.51 shall show the name and address of the insurer and

the seller of the policy or contract and shall state, clearly and conspicuously in boldface type of a minimum size of ten points, a notice in the following form or its equivalent: "RIGHT TO CANCEL. You may cancel this policy by delivering or mailing a written notice or sending a telegram to (insert name and mailing address of the insurer or the seller of the policy or contract) and by returning the policy or contract before midnight of the tenth day after the date you receive the policy. Notice given by mail and return of the policy or contract by mail are effective on being postmarked, properly addressed and postage prepaid. The insurer must return all payments made for this policy within ten days after it receives notice of cancellation and the returned policy." For variable annuity contracts issued pursuant to sections 61A.13 to 61A.21, this notice shall be suitably modified so as to notify the purchaser that the purchaser is entitled to a refund of the amount calculated in accordance with the provisions of section 72A.51, subdivision 3.

Subd. 2. **Noncompliance; cancellation.** If a policy or contract of insurance covered by this section is sold without compliance with subdivision 1, the policy or contract may be canceled by the purchaser at any time within one year after the date of purchase by returning the policy or contract and by giving written notice of cancellation to the insurer or its agent. If a purchaser cancels a policy or contract under this subdivision, the insurer must return the entire consideration paid for the policy or contract within ten days after receiving notice of cancellation and the returned policy or contract, except that if the contract is a variable annuity contract issued pursuant to sections 61A.13 to 61A.21, the insurer shall refund to the purchaser an amount calculated in accordance with the provisions of section 72A.51, subdivision 3.

History: *1977 c 178 s 2; 1980 c 354 s 2; 1986 c 444*

72A.53 VENDING MACHINE SALES.

Sections 72A.51 and 72A.52 shall not apply to insurance sold pursuant to section 60A.18.

History: *1977 c 178 s 3*