FYI EXPRESS

STUDY MANUAL

GEORGIA ACCIDENT & SICKNESS INSURANCE AGENT PRELICENSING

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GEORGIA INSURANCE PRELICENSING INFORMATION

Georgia requires producer licensing candidates to take and complete a state-approved prelicensing course. You will also need to apply for your license with the state insurance department and register for the state licensing exam. Make sure to register for all 3 (prelicensing course, license application, state exam) using the personally identifiable information *exactly as it appears on your government-issued ID*. Discrepancies will delay the licensing process.

HOW DO I COMPLETE MY PRELICENSING EDUCATION COURSE?

Georgia requires 20 hours of prelicensing education for each line of authority, and 40 for a dual line of authority.

To earn your certificate of completion:

- Read every chapter and take the end-of-chapter quiz.
- Score 70% or better on each chapter quiz.
- Complete and pass the Certificate Exam with a minimum score of 70%.

Your exam will be based on the Georgia exam outline, which can be found on pages S4 – S5 in PearsonVUE's Candidate Handbook.

This ebook covers everything insurance agents need to know about Accident & Health Insurance, including different types of coverage, common risks, and best practices for helping clients choose the right policy. It would be a valuable resource for agents looking to expand their knowledge and better serve their clients in the Georgia Access insurance market.

As you go through the eBook and have enjoyed a few topics, I give you the opportunity to test your understanding of what you just read by clicking a link.

The link will take you to a quiz with 10 multiple-choice questions & 4 possible answers.

It is not mandatory to take the quizzes but it sure is fun (especially if you turn on the music, memes & sound effects.

To get the most out of this eBook, you need to sign up for a FREE account at https://quizizz.com/

Being familiar with the questions will come in handy when you take the online Final Exam which consists of 50 multiple-choice questions.

You will need to correctly answer at least 70% of the questions in order to earn 20 hours GA Accident & Sickness Insurance Agent Certificate.

I. TYPES OF POLICIES 11
A. Disability Income 11
1. Individual Disability Income Policy 11
2. Business Overhead Expense Policy 11
3. Business Disability Buyout Policy 11
4. Group Disability Income Policy 11
5. Key Employee Policy 11
B. Accidental Death and Dismemberment 11
C. Medical Expense Insurance 12
1. Basic Hospital, Medical, and Surgical Policies 12
2. Major Medical Policies 12
3. Health Maintenance Organizations (HMOs) 12
4. Preferred Provider Organizations (PPOs) 12
5. Point of Service (POS) Plans 12
6. Flexible Spending Accounts (FSAs) 12
7. High Deductible Health Plans (HDHPs) and Health Savings Accounts 12
8. Health Reimbursement Accounts (HRAs) 13
D. Medicare Supplement Policies 13
E. Group Insurance 14
1. Differences Between Individual and Group Contracts 14
2. General Characteristics 14
3. COBRA 14
F. Individual/Group Long Term Care (LTC) 15
1. Eligibility 15
2. Levels of Care 15
G. Other Policies 15
1. Dental 15
2. Vision 15
3. Cancer Insurance 15

4. Critical Illness or Specified Disease Insurance 15
5. Worksite (Employer-Sponsored) Insurance 15
6. Hospital Indemnity Insurance 16
7. Short-Term Medical Insurance 16
8. Accident Insurance 16
II. POLICY PROVISIONS, CLAUSES, AND RIDERS 16
A. Mandatory and Optional Provisions 16
1. Entire Contract 16
2. Time Limit on Certain Defenses (Incontestable) 16
3. Grace Period 16
4. Reinstatement 17
5. Notice of Claim 17
6. Claim Forms 17
7. Proof of Loss 17
8. Time of Payment of Claims 17
9. Payment of Claims 17
10. Physical Examination and Autopsy 17
11. Legal Actions 17
12. Change of Beneficiary 18
13. Misstatement of Age or Gender 18
14. Change of Occupation 18
15. Illegal Occupation 18
16. Relation of Earnings to Insurance 18
B. Other Provisions and Clauses 18
1. Insuring Clause 18
2. Free Look 19
3. Consideration Clause 19
4. Probationary Period 19
5. Elimination Period 19

6. Waiver of Premium 19
7. Exclusions and Limitations 19
8. Preexisting Conditions 19
9. Coinsurance 20
10. Deductibles 20
11. Eligible Expenses 20
12. Copayments 20
13. Pre-authorizations and Prior Approval Requirements 20
14. Usual, Reasonable, and Customary (URC) Charges 20
15. Lifetime, Annual, or Per Cause Maximum Benefit Limits 21
D. Riders 21
1. Impairment/Exclusions 21
2. Guaranteed Insurability 21
3. Future Increase Option 21
E. Rights of Renewability 21
1. Noncancelable 21
2. Cancelable 22
3. Guaranteed Renewable 22
III. SOCIAL INSURANCE 22
A. Medicare (Parts A, B, C, D) 22
B. Medicaid 22
C. Social Security Benefits 23
IV. OTHER INSURANCE CONCEPTS 23
A. Total, Partial, Recurrent, and Residual Disability 23
B. Owner's Rights 23
C. Dependent Children Benefits 23
D. Primary and Contingent Beneficiaries 24
E. Modes of Premium Payments 24
F. Nonduplication and Coordination of Benefits (e.g., primary vs. excess) 24

G. Occupational vs. Nonoccupational....24
H. Tax Treatment of Premiums and Proceeds of Insurance Contracts (e.g., disability income and medical expenses, etc.)....24
I. Managed Care....25
J. Workers Compensation....25
K. Subrogation....25
V. FIELD UNDERWRITING PROCEDURES....25
A. Completing the Application....25
B. Explaining Sources of Insurability and HIPAA Privacy....25
C. Initial Premium Payment and Receipt and Consequences of the Receipt....26
D. Submitting Application (and Initial Premium if Collected) to Company for Underwriting....26
E. Policy Delivery....26
F. Explaining Policy and Its Provisions, Riders, Exclusions, and Ratings to Clients....26
G. Replacement....26
H. Contract Law....27
1. Elements of a Contract....27
2. Insurable Interest....27
3. Warranties and Representations....27
4. Unique Aspects of the Insurance Contract....27
a. Conditional....27
b. Unilateral....28
c. Adhesion....28
d. Aleatory....28
VI. GEORGIA LAWS, RULES AND REGULATIONS PERTINENT TO LIFE, ACCIDENT & SICKNESS INSURANCE....28
A. Insurance Department and Commissioner....28
1. Broad Powers and Duties....28
2. Examination of Records....29
3. Investigations/Notice of Hearing....29

4. Penalties 29
B. General Insurance Definitions 29
1. Domestic, Foreign, and Alien 29
2. Stock and Mutual 30
3. Authorized/Unauthorized and Certificate of Authority 30
4. Insurance Transaction / Transacting Business 30
C. Licensing of Agents & Counselors 30
1. Agent Responsibility 30
2. License Maintenance 31
3. License Revocation, Suspension, Denial, or Refusal to Renew 31
4. Temporary License 31
5. Nonresident License 31
6. Counselor License 31
D. Unfair Trade Practices 31
1. Rebating 31
2. Defamation 32
3. Unfair Discrimination 32
4. Misrepresentation 32
5. Twisting and Churning 32
6. Advertising 33
7. Coercion 34
8. Controlled Business 34
9. Unfair Claims Practices 34
10. Fraud 34
E. Reporting and Disposition of Premiums 35
1. Fiduciary Responsibility 35
2. Commingling 35
F. Georgia Life and Health Insurance Guaranty Association 35
VII. Georgia Rules and Codes Pertinent to Accident & Sickness Insurance Only 37

A. Individual and Group Accident and Sickness Insurance 37
B. Medicare Supplement 50
C. Long Term Care 54
D. Long Term Care Partnership Requirements 61
Georgia Access 68
Types of disability insurance riders 132
Understanding AD&D Insurance: Benefits & Coverage 139
Vision services or products 143
Major Medical Insurance: What Is It? 148
What is Medigap? 153
Long-Term Care Insurance: What You Need to Know 160
What Is Vision Insurance? 162
Things to know about your insurance if you have cancer 164
What Is Critical Illness Insurance? 164
What Does Insuring Clause Mean? 167
FAQ About Waiver of Premium in Insurance 174
Summary of the HIPAA Privacy Rule 178
What Is a Conditional Binding Receipt? 196
Face-to-Face Delivery 197
Elements Of an Insurance Contract 200
What Does Adhesion Insurance Contract Mean? 202
What Is an Aleatory Contract? 202
Georgia State Laws Dealing with Insurance 203

GEORGIA ACCESS

STARTS NOVEMBER 1ST

I. TYPES OF POLICIES

A. Disability Income

1. Individual Disability Income Policy

- **Description**: Provides income replacement if the insured becomes unable to work due to a disability.
- **Example**: A policy that pays 60% of your salary if you are unable to work due to an illness or injury.

2. Business Overhead Expense Policy

- **Description**: Covers business expenses such as rent, utilities, and employee salaries if the business owner becomes disabled.
- **Example**: A policy that pays $5,000 per month to cover office rent and utilities while the owner is recovering from surgery.

3. Business Disability Buyout Policy

- **Description**: Provides funds to buy out a disabled partner's share of the business.
- **Example**: A policy that pays $500,000 to buy out a partner who can no longer work due to a severe accident.

4. Group Disability Income Policy

- **Description**: Offered by employers, this policy provides disability income benefits to employees.
- **Example**: An employer-provided policy that pays 50% of an employee's salary if they are unable to work due to a long-term illness.

5. Key Employee Policy

- **Description**: Provides benefits to a business if a key employee becomes disabled.
- **Example**: A policy that pays $100,000 to a company if their top sales executive is unable to work for six months due to a disability.

CLICK HERE TO TEST YOUR UNDERSTANDING OF THE PREVIOUS TOPICS

B. Accidental Death and Dismemberment

- **Description**: Provides benefits if the insured dies or loses a limb due to an accident.
- **Example**: A policy that pays $200,000 for accidental death and $100,000 for the loss of a limb.

C. Medical Expense Insurance

1. Basic Hospital, Medical, and Surgical Policies

- **Description**: Covers basic hospital, medical, and surgical expenses.
- **Example**: A policy that covers hospital stays, surgeries, and doctor visits

2. Major Medical Policies

- **Description**: Provides comprehensive coverage for major medical expenses.
- **Example**: A policy that covers extensive medical treatments, including surgeries and hospital stays.

3. Health Maintenance Organizations (HMOs)

- **Description**: Provides health services through a network of providers for a fixed annual fee.
- **Example**: An HMO plan that requires members to choose a primary care physician and get referrals for specialists.

4. Preferred Provider Organizations (PPOs)

- **Description**: Offers more flexibility in choosing healthcare providers and does not require referrals.
- **Example**: A PPO plan that allows members to see any doctor without a referral but offers lower costs for in-network providers.

5. Point of Service (POS) Plans

- **Description**: Combines features of HMOs and PPOs, requiring a primary care physician but allowing out-of-network care at a higher cost.
- **Example**: A POS plan that covers out-of-network visits but at a higher copayment.

6. Flexible Spending Accounts (FSAs)

- **Description**: Allows employees to set aside pre-tax dollars for medical expenses.
- **Example**: An FSA that lets employees use pre-tax dollars for prescriptions and doctor visits.

7. High Deductible Health Plans (HDHPs) and Health Savings Accounts **(HSAs)**

- **Description**: HDHPs have higher deductibles but lower premiums, and HSAs allow pre-tax savings for medical expenses.
- **Example**: An HDHP paired with an HSA that lets employees save pre-tax dollars for future medical expenses.

8. Health Reimbursement Accounts (HRAs)

- **Description**: Employer-funded accounts that reimburse employees for medical expenses.
- **Example**: An HRA that reimburses employees for out-of-pocket medical costs.

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D. Medicare Supplement Policies

- **Description**: Also known as Medigap, these policies cover costs not covered by Original Medicare.
- **Example**: A Medigap Plan G that covers Medicare Part A and B coinsurance and deductibles.

Open Enrollment

Insurers may not deny the issuance of any Medicare supplement policy or discriminate in the pricing of a policy because of the health status, claims experience, or receipt of health care, if an application for a policy has been submitted prior to or within 6 months beginning with the first day of the first month in which the applicant is both: age 65 or older, and is enrolled for benefits under Medicare Part B.

Free Look

Medicare supplement policies must have a notice prominently printed on the first page stating that the policyholder are entitled for a 30-day free-look period, during which the policy can be return with a full refund of premium, if the policyholder is not satisfied with the policy for any reason.

Standards for Marketing

Medicare Supplement policies that are advertised or marketed in this state may not contain limitations or exclusions of coverage, except those permitted by pre-existing condition clauses, that are more restrictive than Medicare. Policies may not use waivers to exclude, limit, or reduce coverage or benefits for specifically named or described pre-existing diseases or conditions.

No supplement policy or certificate in force may contain benefits that duplicate benefits provided by Medicare.

Twisting, high-pressure tactics, and cold lead advertising are prohibited. The terms Medicare Supplement, Medigap, Medicare Wrap-Around, and similar words may not be used unless the policy is in full compliance of the law.

Any sale of a Medicare supplement policy or certificate that will provide an individual more than one Medicare supplement policy or certificate is prohibited.

A Medicare supplement policy or certificate may NOT be issued to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual's Part C coverage.

On or before March 1 of each year, issuers must report the policy number and date of issuance for every individual resident of this state for which the issuer has more than one Medicare supplement policy or certificate in force.

Permitted Compensation

Insurers may provide commissions to insurance producers for the sale of Medicare supplement policies only if the first-year commission does not exceed 200% of the commission or other compensation paid for the sale or servicing of policy in the second year. Commissions provided in subsequent (renewal) years must be the same as that in the second year and must be provided for no fewer than 5 renewal years.

Replacement

Application forms for Medicare supplement insurance policies must include a question to determine if the applicant intends to replace any existing accident and sickness policy with the Medicare supplement policy. If that is so, the insurer or its agent must furnish the applicant with a Notice Regarding Replacement prior to issuing or delivering the Medicare supplement policy.

Replacement notices must be signed by the applicant and the agent. Each party must retain a signed copy.

E. Group Insurance

1. Differences Between Individual and Group Contracts

- **Description**: Group insurance is provided to a group of people under a single contract, usually through an employer.
- **Example**: An employer-provided health insurance plan versus an individually purchased plan.

2. General Characteristics

- **Description**: Group insurance typically offers lower premiums and simplified underwriting.
- **Example**: A group life insurance policy that does not require medical exams for coverage.

3. COBRA

- **Description**: Allows employees to continue their group health insurance coverage after leaving employment.
- **Example**: An employee who continues their health insurance coverage for 18 months after leaving a job.

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F. Individual/Group Long Term Care (LTC)

1. Eligibility

- **Description**: Typically requires the inability to perform at least two activities of daily living (ADLs).
- **Example**: A policyholder who needs help with bathing and dressing qualifies for benefits.

2. Levels of Care

- **Description**: Includes home care, assisted living, and nursing home care.
- **Example**: A policy that covers in-home care services and nursing home stays.

G. Other Policies

1. Dental

- **Description**: Covers dental care expenses such as cleanings, fillings, and orthodontics.
- **Example**: A policy that covers 80% of the cost of dental cleanings and fillings.

2. Vision

- **Description**: Vision insurance covers routine eye care, including eye exams, glasses, and contact lenses.
- **Example**: A policy that covers an annual eye exam and provides a $150 allowance for glasses or contact lenses.

3. Cancer Insurance

- **Description**: Cancer insurance provides a lump-sum benefit upon diagnosis of cancer, helping to cover treatment costs and other expenses.
- **Example**: A policy that pays $50,000 upon diagnosis of cancer, which can be used for medical bills, travel, or household expenses.

4. Critical Illness or Specified Disease Insurance

- **Description**: This insurance provides a lump-sum payment if the insured is diagnosed with a specified critical illness, such as heart attack, stroke, or cancer.
- **Example**: A policy that pays $25,000 upon diagnosis of a heart attack, which can be used for medical and non-medical expenses.

5. Worksite (Employer-Sponsored) Insurance

- **Description**: These are voluntary benefits offered by employers, including health, dental, vision, and life insurance, often at reduced rates.
- **Example**: An employer-sponsored plan that includes health, dental, and vision insurance, with premiums partially paid by the employer.

6. Hospital Indemnity Insurance

- **Description**: Provides a fixed daily, weekly, or monthly benefit if the insured is hospitalized, helping to cover out-of-pocket expenses.
- **Example**: A policy that pays $200 per day for each day the insured is hospitalized.

7. Short-Term Medical Insurance

- **Description**: Provides temporary health coverage for a limited period, typically up to 12 months, for individuals between jobs or waiting for other coverage.
- **Example**: A policy that covers emergency room visits and hospital stays for up to six months.

8. Accident Insurance

- **Description**: Provides a lump-sum benefit for injuries resulting from accidents, covering medical and non-medical expenses.
- **Example**: A policy that pays $5,000 for a broken leg resulting from a car accident.

CLICK HERE TO TEST YOUR UNDERSTANDING OF THE PREVIOUS TOPICS

II. POLICY PROVISIONS, CLAUSES, AND RIDERS

A. Mandatory and Optional Provisions

1. Entire Contract

- **Description**: The policy and the application constitute the entire contract between the insurer and the insured.
- **Example**: Ensures that no external documents can alter the terms of the policy.

2. Time Limit on Certain Defenses (Incontestable)

- **Description**: Limits the time during which the insurer can contest the policy based on misstatements in the application.
- **Example**: Typically, after two years, the insurer cannot contest the policy except for fraud.

3. Grace Period

- **Description**: A period after the premium due date during which the policy remains in force without penalty.
- **Example**: A 30-day grace period for premium payments.

4. Reinstatement

- **Description**: Allows a lapsed policy to be reinstated within a certain period, usually with proof of insurability and payment of back premiums.
- **Example**: A policy that can be reinstated within five years of lapse.

5. Notice of Claim

- **Description**: The insured must notify the insurer of a claim within a specified time period.
- **Example**: A requirement to notify the insurer within 20 days of a loss.

6. Claim Forms

- **Description**: The insurer must provide claim forms to the insured within a specified time period after receiving notice of a claim.
- **Example**: Insurer must send claim forms within 15 days of notification.

7. Proof of Loss

- **Description**: The insured must provide proof of loss within a specified time period.
- **Example**: Proof of loss must be submitted within 90 days of the loss.

8. Time of Payment of Claims

- **Description**: Specifies the time period within which the insurer must pay claims after receiving proof of loss.
- **Example**: Claims must be paid within 60 days of receiving proof of loss.

CLICK HERE TO TEST YOUR UNDERSTANDING OF THE PREVIOUS TOPICS

9. Payment of Claims

- **Description**: Specifies to whom the claims are payable.
- **Example**: Claims are payable to the insured or the beneficiary.

10. Physical Examination and Autopsy

- **Description**: Allows the insurer to require a physical examination or autopsy to determine the cause of death.
- **Example**: Insurer may require an autopsy in case of accidental death.

11. Legal Actions

- **Description**: Limits the time period within which the insured can bring legal action against the insurer.
- **Example**: Legal action must be brought within three years of the claim denial.

12. Change of Beneficiary

- **Description**: Allows the policyholder to change the beneficiary designation.
- **Example**: Policyholder can change the beneficiary by submitting a written request to the insurer.

13. Misstatement of Age or Gender

- **Description**: Adjusts the benefits if the insured's age or gender was misstated on the application.
- **Example**: Benefits are adjusted to what the premiums would have purchased at the correct age or gender.

14. Change of Occupation

- **Description**: Adjusts the premium or benefits if the insured changes to a more hazardous occupation.
- **Example**: Premiums are increased if the insured changes from an office job to a construction job.

15. Illegal Occupation

- **Description**: Excludes coverage if the insured is injured or dies while committing an illegal act.
- **Example**: No benefits

16. Relation of Earnings to Insurance

Description: This provision allows the insurer to limit the insured's benefits based on their average monthly earnings for the previous two years[1].

- **Example**: If an insured person has a disability policy that pays $5,000 per month but their average monthly earnings were only $3,000, the insurer may reduce the benefit to $3,000.

CLICK HERE TO TEST YOUR UNDERSTANDING OF THE PREVIOUS TOPICS

B. Other Provisions and Clauses

1. Insuring Clause

Description: The insuring clause is the part of the insurance policy that outlines the insurer's promise to pay benefits upon the occurrence of a specified event, such as the death of the insured[2].

Example: In a life insurance policy, the insuring clause states that the insurer will pay a death benefit to the beneficiary upon the death of the insured.

2. Free Look

Description: The free look provision allows the policyholder to review the policy for a specified period (usually 10 days) and return it for a full refund if they are not satisfied[1].

Example: A policyholder receives their new life insurance policy and decides within 10 days that it does not meet their needs. They return the policy and receive a full refund of the premium paid.

3. Consideration Clause

Description: The consideration clause specifies the amount and frequency of premium payments that the policyholder must make to keep the insurance policy in force[3].

Example: A life insurance policy might require monthly premium payments of $100 to maintain coverage.

4. Probationary Period

Description: The probationary period is the time period that must pass before coverage for certain conditions begins[4].

Example: A health insurance policy might have a 30-day probationary period for coverage of preexisting conditions.

5. Elimination Period

Description: The elimination period is the waiting period between the onset of a disability and the time benefits begin to be paid[5].

Example: A disability insurance policy might have a 90-day elimination period, meaning benefits start 90 days after the insured becomes disabled.

6. Waiver of Premium

Description: The waiver of premium rider allows the policyholder to stop paying premiums if they become disabled and are unable to work[6].

Example: If a policyholder becomes permanently disabled, the waiver of premium rider would allow them to maintain their life insurance coverage without paying premiums.

7. Exclusions and Limitations

Description: Exclusions and limitations are specific conditions or circumstances for which the policy will not provide benefits[7].

Example: A life insurance policy might exclude coverage for death resulting from suicide within the first two years of the policy.

8. Preexisting Conditions

Description: A preexisting condition is any health issue or condition that existed before the insurance coverage began[8].

Example: If an individual has diabetes before applying for health insurance, it is considered a preexisting condition.

CLICK HERE TO TEST YOUR UNDERSTANDING OF THE PREVIOUS TOPICS

9. Coinsurance

Description: Coinsurance is the percentage of costs that the insured must pay after the deductible has been met[3].

Example: If a health insurance policy has an 80/20 coinsurance clause, the insurer pays 80% of covered expenses, and the insured pays 20%.

10. Deductibles

Description: A deductible is the amount the insured must pay out-of-pocket before the insurance company begins to pay for covered expenses[3].

Example: A health insurance policy might have a $1,000 deductible, meaning the insured pays the first $1,000 of covered expenses each year.

11. Eligible Expenses

Description: Eligible expenses are medical costs that are covered by the insurance policy[3].

Example: Eligible expenses under a health insurance policy might include hospital stays, surgeries, and prescription medications.

12. Copayments

Description: A copayment is a fixed amount the insured must pay for a covered service at the time of service[3].

Example: A health insurance policy might require a $20 copayment for each doctor's visit.

13. Pre-authorizations and Prior Approval Requirements

Description: Pre-authorizations and prior approval requirements are processes that require the insured to obtain approval from the insurer before receiving certain services[3].

Example: A health insurance policy might require pre-authorization for elective surgeries.

14. Usual, Reasonable, and Customary (URC) Charges

Description: URC charges are the amounts typically charged for a particular service in a specific geographic area[3].

Example: If a doctor charges $200 for a service, but the URC charge is $150, the insurance company may only pay $150.

15. Lifetime, Annual, or Per Cause Maximum Benefit Limits

Description: These limits cap the amount the insurer will pay over the lifetime of the policy, annually, or per cause[3].

Example: A health insurance policy might have a $1 million lifetime maximum benefit limit, meaning the insurer will not pay more than $1 million over the life of the policy.

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D. Riders

1. Impairment/Exclusions

Description: Impairment or exclusion riders are provisions in an insurance policy that exclude coverage for certain conditions or activities that pose a higher risk[1].

Example: If an individual has a preexisting heart condition, an impairment rider might exclude coverage for any medical expenses related to heart issues.

2. Guaranteed Insurability

Description: The guaranteed insurability rider allows the policyholder to purchase additional insurance coverage at specified times without undergoing a new medical examination[2].

Example: A policyholder can increase their life insurance coverage when they reach certain ages or life events, such as marriage or the birth of a child, without proving insurability.

3. Future Increase Option

Description: The future increase option rider allows the policyholder to increase their coverage amount at future dates without providing evidence of insurability[1].

Example: A policyholder can opt to increase their disability insurance coverage every few years to keep up with inflation or salary increases.

E. Rights of Renewability

1. Noncancelable

Description: A noncancelable policy guarantees that the insurer cannot cancel the policy or increase the premiums as long as the policyholder continues to pay the premiums[1].

Example: A noncancelable disability insurance policy ensures that the policyholder's coverage and premium rates remain unchanged until the policy expires.

2. Cancelable

Description: A cancelable policy allows the insurer to cancel the policy at any time, usually with a notice period[1].

Example: A health insurance policy that can be canceled by the insurer with a 30-day notice period.

3. Guaranteed Renewable

Description: A guaranteed renewable policy ensures that the policyholder can renew the policy without providing evidence of insurability, although the insurer can increase the premiums[1].

Example: A health insurance policy that the policyholder can renew each year regardless of their health status, but the insurer may adjust the premium rates.

CLICK HERE TO TEST YOUR UNDERSTANDING OF THE PREVIOUS TOPICS

III. SOCIAL INSURANCE

A. Medicare (Parts A, B, C, D)

Description: Medicare is a federal health insurance program primarily for individuals aged 65 and older, but also for some younger people with disabilities. It has four parts:

- **Part A**: Covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care[1].
- **Part B**: Covers certain doctors' services, outpatient care, medical supplies, and preventive services[1].
- **Part C (Medicare Advantage)**: An alternative to Original Medicare that includes Parts A and B and often Part D, offered by private companies approved by Medicare[2].
- **Part D**: Provides prescription drug coverage[2].
- **Example**: An individual turning 65 enrolls in Medicare Part A and Part B, and then chooses a Medicare Advantage plan (Part C) that includes prescription drug coverage (Part D).
- **More Information**: Medicare Parts A, B, C, and D - Medicare.org

B. Medicaid

Description: Medicaid is a joint federal and state program that helps with medical costs for some people with limited income and resources. It also offers benefits not normally covered by Medicare, like nursing home care and personal care services[3].

Example: A low-income family with children may qualify for Medicaid to cover their healthcare costs.

More Information: Medicaid - Medicaid.gov

C. Social Security Benefits

Description: Social Security provides financial assistance to retirees, disabled individuals, and survivors of deceased workers. Benefits include retirement income, disability income, and survivor benefits[4].

Example: A retired worker who has paid into Social Security for at least 10 years receives monthly retirement benefits starting at age 62 or later.

More Information: Social Security Benefits - SSA.gov

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IV. OTHER INSURANCE CONCEPTS

A. Total, Partial, Recurrent, and Residual Disability

Description: These terms refer to different levels and types of disability coverage:

- **Total Disability**: The inability to perform any of the duties of one's occupation[5].
- **Partial Disability**: The inability to perform some, but not all, of the duties of one's occupation[5].
- **Recurrent Disability**: A disability that recurs after the insured has returned to work[5].
- **Residual Disability**: Provides benefits if the insured can work but at a reduced capacity, resulting in a loss of income[5].
- **Example**: A surgeon who injures their hand and can no longer perform surgeries may receive total disability benefits. If they can still perform some tasks but not all, they may receive partial or residual disability benefits.
- **More Information**: Residual or Partial Disability Benefits - Maddox Firm

B. Owner's Rights

Description: The policy owner has the legal rights to make decisions about the policy, including naming beneficiaries, borrowing against the policy, and transferring ownership[6].

Example: The owner of a life insurance policy can change the beneficiary from one family member to another.

More Information: Ownership Clause in Life Insurance - LiveWell

C. Dependent Children Benefits

Description: Health insurance plans often cover dependent children up to a certain age, typically 26, under the Affordable Care Act[7].

Example: A 24-year-old college student remains covered under their parent's health insurance plan.

More Information: Dependent Child Coverage - HealthCare.gov

D. Primary and Contingent Beneficiaries

Description: A primary beneficiary is the first in line to receive the death benefit from an insurance policy. A contingent beneficiary receives the benefit if the primary beneficiary is unable to[8].

Example: A policyholder names their spouse as the primary beneficiary and their children as contingent beneficiaries.

More Information: Primary vs. Contingent Beneficiary - Cake

E. Modes of Premium Payments

Description: The frequency with which premium payments are made, such as monthly, quarterly, semi-annually, or annually[9].

Example: A policyholder chooses to pay their life insurance premium monthly instead of annually.

More Information: Mode of Premium - Investopedia

F. Nonduplication and Coordination of Benefits (e.g., primary vs. excess)

Description: Coordination of benefits ensures that when a person is covered by multiple insurance plans, the benefits are coordinated to avoid over-insurance or duplication of benefits[10].

Example: If a person has two health insurance plans, one plan will be designated as primary and the other as secondary to ensure the total benefits do not exceed the actual medical expenses.

More Information: Coordination of Benefits - ADA

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G. Occupational vs. Nonoccupational

Description: Occupational insurance covers injuries or illnesses that occur at work, while nonoccupational insurance covers those that occur outside of work[11].

Example: Workers' compensation is an example of occupational insurance, while a standard health insurance policy may provide nonoccupational coverage.

More Information: Occupational vs. Non-Occupational Insurance - Study.com

H. Tax Treatment of Premiums and Proceeds of Insurance Contracts (e.g., disability income and medical expenses, etc.)

Description: The tax treatment of insurance premiums and proceeds varies depending on the type of insurance and the specific circumstances. Generally, life insurance death benefits are tax-free, while disability income benefits may be taxable[4].

Example: Life insurance death benefits received by beneficiaries are typically not subject to federal income tax.

More Information: Tax Treatment of Insurance - IRS.gov

I. Managed Care

Description: Managed care plans are health insurance plans that contract with healthcare providers and medical facilities to provide care for members at reduced costs. These plans include HMOs, PPOs, and POS plans[4].

Example: An HMO plan requires members to choose a primary care physician and get referrals to see specialists.

J. Workers Compensation

Description: Workers' compensation is a form of insurance that provides wage replacement and medical benefits to employees injured in the course of employment[4].

Example: An employee who is injured on the job receives medical treatment and a portion of their lost wages through workers' compensation insurance.

More Information: Workers Compensation - U.S. Department of Labor

K. Subrogation

Description: Subrogation is the process by which an insurance company seeks reimbursement from the responsible party for a claim it has already paid[4].

Example: If an insurance company pays for damages caused by a third party, it may seek to recover those costs from the third party.

More Information: Subrogation – Investopedia

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V. FIELD UNDERWRITING PROCEDURES

A. Completing the Application

Description: Completing a life insurance application involves gathering personal, financial, and medical information about the applicant. This information helps the insurer assess the risk and determine the premium rates.

Example: An applicant provides details about their age, occupation, health history, and lifestyle habits.

More Information: MarketWatch Guide to Filling Out a Life Insurance Application[1].

B. Explaining Sources of Insurability and HIPAA Privacy

Description: Insurers use various sources to verify an applicant's insurability, such as the Medical Information Bureau (MIB) report and credit reports. The Health Insurance Portability and Accountability Act (HIPAA) ensures the privacy and security of health information.

Example: An insurer may request an attending physician's statement (APS) to get detailed medical history.

More Information: HIPAA Privacy Rule Summary[2].

C. Initial Premium Payment and Receipt and Consequences of the Receipt

Description: The initial premium payment is often required when submitting the application. A receipt, such as a conditional receipt, may be issued, which can provide temporary coverage until the policy is approved or denied.

Example: An applicant pays the first premium and receives a conditional receipt, which provides coverage if they meet the underwriting requirements.

More Information: Investopedia on Conditional Binding Receipt[3].

D. Submitting Application (and Initial Premium if Collected) to Company for Underwriting

Description: After completing the application and collecting the initial premium, the application is submitted to the insurance company for underwriting. The underwriter assesses the risk and decides whether to approve the policy.

Example: An agent submits the application and initial premium to the insurer, who then reviews the applicant's medical records and other information.

More Information: The Zebra on Life Insurance Underwriting[4].

E. Policy Delivery

Description: Once the policy is approved, it is delivered to the policyholder. The delivery date is important as it marks the start of the coverage and the free-look period.

Example: An agent delivers the policy to the policyholder, who then has a certain period to review and return it if they are not satisfied.

More Information: Principal Financial Group on Policy Delivery[5].

F. Explaining Policy and Its Provisions, Riders, Exclusions, and Ratings to Clients

Description: The agent explains the details of the policy, including its provisions, riders (additional benefits), exclusions (what is not covered), and ratings (premium adjustments based on risk).

Example: An agent explains to a client that their policy includes an accidental death rider but excludes coverage for certain high-risk activities.

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G. Replacement

Description: Replacement involves canceling an existing policy and purchasing a new one. This process is regulated to protect consumers from unnecessary replacements that may not be in their best interest.

Example: A policyholder replaces their current policy with a new one that offers better coverage and lower premiums.

More Information: Investopedia on Life Insurance Replacement[7].

H. Contract Law

1. Elements of a Contract

Description: A valid contract must have an offer and acceptance, consideration, competent parties, and a legal purpose.

Example: An insurance policy is a contract where the insurer promises to pay a death benefit in exchange for premium payments.

More Information: Insuranceopedia on Elements of an Insurance Contract[8].

2. Insurable Interest

Description: Insurable interest means the policyholder must have a legitimate interest in the continued life of the insured.

Example: A spouse has an insurable interest in their partner's life.

More Information: ThinkAdvisor on Insurable Interest[9].

3. Warranties and Representations

Description: Warranties are statements guaranteed to be true, while representations are statements believed to be true to the best of the applicant's knowledge.

Example: An applicant states they do not smoke (representation) and guarantees their age is correct (warranty).

More Information: Insuranceopedia on Warranties and Representations[8].

4. Unique Aspects of the Insurance Contract

Description: Insurance contracts have unique characteristics such as being conditional, unilateral, contracts of adhesion, and aleatory.

Example: An insurance contract is unilateral because only the insurer makes a legally enforceable promise.

More Information: Henssler Financial on Life Insurance Contractual Obligations[10].

Unique Aspects of the Insurance Contract

a. Conditional

Description: An insurance contract is conditional because the insurer's obligation to pay a claim is dependent on the occurrence of a specified event and the fulfillment of certain conditions by the insured.

Example: If a policyholder files a claim for a car accident, the insurer will only pay if the accident is covered under the policy and the policyholder has met all conditions, such as paying premiums and reporting the accident promptly.

b. Unilateral

Description: A unilateral contract is one in which only one party, the insurer, makes a legally enforceable promise. The insured does not make any promises but must fulfill certain conditions, such as paying premiums, to keep the policy in force.

Example: In a life insurance policy, the insurer promises to pay a death benefit if the insured dies during the policy term, provided the premiums have been paid.

More Information: Unilateral Contracts in Insurance[2].

c. Adhesion

Description: An adhesion contract is one drafted by the insurer, where the insured has little to no ability to negotiate the terms. The insured must accept the contract as is or not at all.

Example: When purchasing a standard auto insurance policy, the policyholder must accept the terms set by the insurer without negotiation.

More Information: Adhesion Insurance Contract[3].

d. Aleatory

Description: An aleatory contract is one where the performance of one or both parties is dependent on an uncertain event. In insurance, this means the insurer only pays out if a specified event, such as a loss or death, occurs.

Example: A homeowner's insurance policy is aleatory because the insurer only pays if there is damage to the home due to a covered peril, like a fire.

More Information: Aleatory Contract in Insurance[4].

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VI. GEORGIA LAWS, RULES AND REGULATIONS PERTINENT TO LIFE, ACCIDENT & SICKNESS INSURANCE

A. Insurance Department and Commissioner

1. Broad Powers and Duties

The Georgia Insurance Commissioner has broad powers and duties, including regulating insurance companies, ensuring compliance with state laws, and protecting consumers. The Commissioner can issue rules and regulations, conduct investigations, and enforce penalties.

Example: The Commissioner can revoke an insurance company's license if it violates state laws.

More Information: Georgia Code § 33-2-1 through 6; 9 through 32

2. Examination of Records

The Commissioner has the authority to examine the records of insurance companies to ensure compliance with state laws. This includes reviewing financial statements, policyholder records, and other relevant documents.

Example: An insurance company may be required to submit its financial records for examination to verify solvency.

More Information: Georgia Code § 33-2-10 through 13

3. Investigations/Notice of Hearing

The Commissioner can conduct investigations into potential violations of insurance laws and issue notices of hearings to address these issues.

Example: If an insurance company is suspected of fraud, the Commissioner can investigate and hold a hearing to determine the appropriate action.

If, after a hearing, the Commissioner determines that the person charged has engaged in an unfair method of competition or an unfair or deceptive act or practice, the Commissioner will send to the person a written copy of the violations and a **cease and desist order** requiring the person to stop engaging in such method of competition, act, practice, or violation. The Commissioner may also impose one or more of the following penalties:

- A monetary fine up to $1,000 for each violation, or $5,000 for willful violations, where a person knew or reasonably should have known they were in violation;
- Suspension or revocation of the person's license if the person has knowingly committed the violation; or

Any other relief as is reasonable and appropriate.

More Information: Georgia Code § 33-6-6

4. Penalties

The Commissioner can impose penalties on insurance companies and agents for violations of state laws. Penalties can include fines, license suspension, or revocation.

Example: An insurance agent found guilty of fraud may face fines and have their license revoked.

More Information: Georgia Code § 33-6-9

B. General Insurance Definitions

1. Domestic, Foreign, and Alien

- **Domestic Insurer**: An insurer formed under the laws of Georgia.
- **Foreign Insurer**: An insurer formed under the laws of another state within the U.S.
- **Alien Insurer**: An insurer formed under the laws of a country other than the U.S.

Example: A Georgia-based insurance company is a domestic insurer in Georgia but a foreign insurer in Florida.

More Information: Georgia Code § 33-3-1

2. Stock and Mutual

- **Stock Insurance Company**: Owned by shareholders who may receive dividends.
- **Mutual Insurance Company**: Owned by policyholders who may receive dividends.

Example: State Farm is a mutual insurance company, while Allstate is a stock insurance company.

More Information: Georgia Code § 33-14-2

3. Authorized/Unauthorized and Certificate of Authority

- **Authorized Insurer**: An insurer with a certificate of authority to operate in Georgia.
- **Unauthorized Insurer**: An insurer without a certificate of authority.

Example: An insurer must obtain a certificate of authority from the Commissioner to legally sell insurance in Georgia.

More Information: Georgia Code § 33-3-2 through 5; 33-3-13 through 30

4. Insurance Transaction / Transacting Business

Transacting insurance includes activities such as soliciting, negotiating, and selling insurance policies.

Example: An insurance agent meeting with a client to discuss policy options is transacting insurance.

More Information: Georgia Code § 33-1-2

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C. Licensing of Agents & Counselors

1. Agent Responsibility

Insurance agents must act in the best interest of their clients, provide accurate information, and comply with state laws.

Example: An agent must disclose all policy details to a client and ensure they understand the terms.

More Information: Agents & Agency Licensing

2. License Maintenance

Agents must renew their licenses periodically and complete continuing education requirements.

Example: An insurance agent must complete a certain number of continuing education hours every two years to maintain their license.

More Information: Agent Licensing & Renewals

3. License Revocation, Suspension, Denial, or Refusal to Renew

The Commissioner can revoke, suspend, deny, or refuse to renew an agent's license for violations of state laws.

Example: An agent found guilty of unethical practices may have their license revoked.

More Information: Georgia Code Title 33, Chapter 23

4. Temporary License

A temporary license may be issued to an individual under certain circumstances, such as the death of an agent.

Example: A temporary license may be granted to a spouse of a deceased agent to continue the business.

More Information: Temporary License Information

5. Nonresident License

Nonresident licenses are issued to agents who are licensed in another state but wish to operate in Georgia.

Example: An agent licensed in Florida can apply for a nonresident license to sell insurance in Georgia.

More Information: Nonresident License Information

6. Counselor License

Insurance counselors provide advice on insurance policies and must be licensed to do so.

Example: A licensed insurance counselor can help clients choose the best insurance policies for their needs.

More Information: Counselor License Information

D. Unfair Trade Practices

1. Rebating

Rebating involves returning a portion of the premium or the agent's commission to the insured or offering any other inducement not specified in the policy.

Example: An agent offers a client a portion of their commission as a rebate to encourage them to purchase a policy.

It is unlawful to pay, offer or accept any of the following as an **inducement** to buy insurance:

- Any special favor or advantage in dividends or benefits;
- Any stocks, bonds, securities, or accrued dividends or profits; or
- Anything of value not specified in the insurance contract.

In Georgia, the regulation regarding unlawful inducement does not apply to the insurer's advertising or promotional programs in which insureds or prospective insureds may be given articles of merchandise, prizes, store gift cards, gift certificates, or sporting event tickets not exceeding **$100** in value per person in any one calendar year, as long as the giving of the item of value is not contingent upon the sale or renewal of a policy.

More Information: Georgia Code § 33-6-4 and 5

2. Defamation

Defamation in insurance involves making false or maliciously critical statements about an insurer's financial condition or business practices.

Example: An agent spreads false rumors about a competitor's financial instability to gain business.

More Information: Georgia Code § 33-6-4

3. Unfair Discrimination

Unfair discrimination occurs when insurers make distinctions between individuals of the same class and risk without a valid reason.

Example: Charging different premiums to individuals of the same age and health status without a justified reason.

More Information: Georgia Code § 33-6-4

4. Misrepresentation

Misrepresentation involves providing false or misleading information about the terms, benefits, or advantages of an insurance policy.

Example: An agent exaggerates the benefits of a policy to make a sale.

More Information: Georgia Code § 33-6-4

5. Twisting and Churning

- **Twisting**: Inducing a policyholder to lapse or switch policies through misrepresentation.
- **Churning**: Replacing policies within the same company to earn additional commissions.

Example: An agent persuades a client to switch to a new policy by falsely claiming it offers better benefits.

More Information: Georgia Code § 33-6-34

6. Advertising

Insurance advertising must be truthful and not misleading. It should provide clear and accurate information about the policy.

Example: An advertisement falsely claims that a policy covers all medical expenses without any exclusions.

Advertising

Advertisements for accident or sickness insurance policies must be accurate and sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Advertisements must be **truthful and not misleading** in fact or in implication and must clearly and accurately state the dollar limits and time limits of benefits where applicable.

Advertisements for policies providing benefits only for specified illnesses or accidents must clearly and conspicuously in prominent type state the limited nature of the policy. If a policy provides different benefits for the same loss occurring under different circumstances or from different causes, the smaller benefits payable must be given the same prominence as the larger benefits.

All policies advertised must be identified by names that reasonably describe their contents; *for example*, Hospital and Surgical Expense Policy, Hospital Income Policy, or Disability Income Policy.

Any optional benefit advertised must be labeled as such and must be prominently and conspicuously displayed in conjunction with the conditions to qualify for the benefits. The advertisement must disclose that an additional premium may be charged for each optional benefit.

Advertisements must include the name, address, and phone number of the home or principal office of the nearest authorized representative of the insurer.

Any advertisement making reference to "Medicare Supplement Insurance" or to coverage designed to supplement "Medicare," must contain a clear, prominent, and conspicuous statement in language identical to or substantially the same as the following: "THIS IS A LIMITED POLICY DESIGNED TO COVER ONLY THOSE EXPENSES WHICH MEDICARE DOES NOT COVER."

Any advertisement that refers to the maximum benefits paid for any period greater than one day must disclose at the same time the daily rate of benefits, and when applicable, the fact that the benefits are payable only for the actual number of days of hospital confinement and, when applicable, the limit on the number of days for which coverage is provided.

Testimonials

Testimonials used in advertisements must be genuine, represent the current opinion of the author, be applicable to the policy advertised, and be accurately reproduced.

If the person making a testimonial has a financial interest in the insurer or a related entity, that must be prominently disclosed in the advertisement.

If a person is compensated for making a testimonial, that must be prominently disclosed in the advertisement by language identical or similar to the following: "THIS IS A PAID ENDORSEMENT."

More Information: Georgia Code § 33-6-35

7. Coercion

Coercion involves using force or threats to compel someone to purchase insurance.

Example: An agent threatens to cancel a client's existing policy unless they purchase an additional policy.

It is illegal to be involved in any activity of coercion which is intended to restrict fair trade or to create a monopoly. **Coercion** is an unfair trade practice in which an agent uses physical or mental force with the intent of inducing an applicant to purchase insurance.

More Information: Georgia Code § 33-9-36

8. Controlled Business

Controlled business refers to insurance written primarily for the agent's own interests or those of their family or employer.

Example: An agent writes most of their policies for their own family members.

Controlled business is any coverage written on a producer's own life, health or property, and/or that of the producer's immediate family or business associates. A licensee is not allowed to collect commissions on controlled business above the state-specified limit. In the state of Georgia, a license will not be issued to a person if it is determined that the primary purpose of the license is to write controlled business. **No more than 25%** of the agent's volume of insurance per calendar year can be issued on controlled business.

More Information: Georgia Code § 33-23-1

9. Unfair Claims Practices

Unfair claims practices include actions like delaying claim payments, denying claims without a valid reason, or failing to investigate claims properly.

Example: An insurer delays payment of a legitimate claim without providing a valid reason.

More Information: Georgia Code § 33-6-34

10. Fraud

Insurance fraud involves deceitful practices to gain an unfair advantage, such as filing false claims or providing false information on an application.

Example: A policyholder submits a false claim for damages that never occurred.

More Information: Georgia Code § 33-6-4

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E. Reporting and Disposition of Premiums

1. Fiduciary Responsibility

Agents have a fiduciary responsibility to handle premiums and other funds in a trustworthy manner, ensuring they are used appropriately and not for personal gain.

Example: An agent must deposit client premiums into a separate trust account and not use them for personal expenses.

More Information: Georgia Code § 33-23-35

2. Commingling

Commingling occurs when an agent mixes personal funds with client premiums, which is prohibited.

Example: An agent deposits client premiums into their personal bank account.

More Information: Georgia Code § 33-23-35

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F. Georgia Life and Health Insurance Guaranty Association

The Georgia Life and Health Insurance Guaranty Association protects policyholders if an insurance company becomes insolvent. It provides coverage for life, health, and annuity policies up to certain limits.

Example: If an insurance company goes bankrupt, the association ensures that policyholders still receive their benefits up to the covered limits.

More Information: Georgia Code § 33-38-1 through 10

GA CODE § 33-38-1: Purpose

Summary: This section outlines the purpose of the chapter, which is to protect policyholders against the failure of insurers to fulfill their contractual obligations due to insolvency or impairment. It establishes an association of member insurers to guarantee payment of benefits and continuation of coverage.

Example: If an insurance company providing life insurance becomes insolvent, the association steps in to ensure that policyholders still receive their benefits.

GA CODE § 33-38-2: Scope

Summary: This section defines the types of policies and contracts covered under this chapter, including direct, nongroup life insurance, health insurance, and annuities. It specifies the persons eligible for coverage.

Example: A person holding a direct, nongroup health insurance policy from a member insurer would be covered under this chapter if the insurer becomes insolvent.

GA CODE § 33-38-3: Construction

Summary: This section states that the chapter should be construed to effectuate its purpose as outlined in § 33-38-1.

Example: In legal disputes, interpretations of this chapter should favor protecting policyholders as intended by the chapter's purpose.

GA CODE § 33-38-4: Definitions

Summary: This section provides definitions for terms used in the chapter, such as "account," "affiliate," and "authorized assessment."

Example: "Account" refers to the two accounts created under § 33-38-5, which are used for administration and assessment purposes.

GA CODE § 33-38-5: Creation; Required Membership; Functions and Powers

Summary: This section establishes the Georgia Life and Health Insurance Guaranty Association, outlines its required membership, and details its functions and powers.

Example: All life and health insurers operating in Georgia must be members of this association and contribute to its funding.

GA CODE § 33-38-6: Membership of the Board of Directors; Vacancies; Compensation and Reimbursement of Expenses

Summary: This section describes the composition of the board of directors for the association, how vacancies are filled, and the rules for compensation and reimbursement of expenses.

Example: The board consists of 7 to 11 members selected by the Commissioner from a list provided by the board.

GA CODE § 33-38-7: Powers and Duties of the Association

Summary: This section outlines the powers and duties of the association, including guaranteeing benefits, providing coverage, and assisting in the detection and prevention of insurer impairments.

Example: The association may adopt alternative policies to ensure continued coverage for policyholders of an insolvent insurer.

GA CODE § 33-38-8: Submission of Plan of Operation; Contents; Compliance With Such Plan

Summary: This section requires the association to submit a plan of operation to the Commissioner for approval, detailing how the association will be administered.

Example: The plan might include procedures for assessing member insurers and handling claims.

GA CODE § 33-38-9: Delegation of Powers and Duties of the Association

Summary: This section allows the association to delegate its powers and duties to a similar organization, with the approval of the board of directors and the Commissioner.

Example: The association could delegate its responsibilities to a national guaranty association if it provides similar protections.

GA CODE § 33-38-10: Duties and Powers of the Commissioner

Summary: This section details additional duties and powers of the Commissioner, such as providing premium statements and demanding insurers to make good on impairments.

Example: If an insurer is declared impaired, the Commissioner can demand that the insurer rectify the impairment within a reasonable time.

CLICK HERE TO TEST YOUR UNDERSTANDING OF THE PREVIOUS TOPICS

VII. Georgia Rules and Codes Pertinent to Accident & Sickness Insurance Only

A. Individual and Group Accident and Sickness Insurance

These regulations cover the requirements for individual and group accident and sickness insurance policies, including policy provisions, benefits, and exclusions.

Example: Policies must include specific benefits and cannot exclude coverage for certain pre-existing conditions.

Accident and sickness insurance is provided under a policy that insures one person and their dependents.

It is illegal for contracts to contain provisions that exclude or reduce coverage for an insurable person solely because the person is eligible for or receiving medical assistance.

Basic insurance policy forms or application forms must be filed with the Commissioner for approval at least **90 days before use**. At the end of the 90 days, the form will be considered approved, unless previously approved or disapproved. The Commissioner may extend the approval period by 90 days but must give notice before the end of the initial approval period. At the end of the extension, the form will be considered approved, unless previously approved or disapproved.

Every individual accident and sickness policy must provide for a **10-day free-look period** that allows the policyowner to return the policy if dissatisfied for any reason. Upon the return of the policy, the insurer must refund any premium paid, and the policy will be considered void from its inception.

Optional Provisions

An insurer may, at its option, include any of the following optional provisions:

- **Change of occupation** — if the insured makes a change in occupation, upon claim, the insurer will either reduce the benefits to what premiums paid would have purchased assuming the more hazardous occupation or reduce the premium and return the excess pro rate unearned premium if the change is to a less hazardous occupation.

- **Misstatement of age** — the insurer will adjust the amount payable under the policy according to what the premium paid would have bought at the correct age of the insured.
- **Other insurance in this insurer** — if a policyholder holds multiple policies with the same company and the aggregate coverage is in excess of the maximum limit of indemnity,
  - The excess insurance will be void, and the insurer will return all premiums paid for the excess; or
  - The insured may choose which policy will remain in effect, and the insurer will return all premiums paid for all other policies.
- **Relations of earnings to insurance** — insurer may limit the insured's benefits based on their average monthly earnings for the previous 2 years.
- **Unpaid premium** — upon the payment of a claim, any unpaid premium that is due to the insurer will be deducted from the benefit.
- **Return of premium on cancellation** — if the insured cancels a policy, the earned premium will be computed on a short-rate basis.
- **Conformity with state statutes** — any provision that is in conflict with the statutes of the state in which the insured resides will be amended to conform to the minimum requirements of the statutes.
- **Illegal occupation** — the insurer is not liable for any loss sustained as a result of the insured's commission or attempted commission of a felony, or for any loss contributed to by the insured’s engagement in an illegal occupation.
- **Intoxicants and narcotics** — the insurer is not liable for any loss sustained as a result of the insured's being intoxicated or under the influence of any non-prescribed narcotic.
- **Cancellation of travel accident policies** — the insurer reserves the right to cancel the policy for allowable reasons with a required notice, as specified in the Insurance Code.

Every authorized insurer that issues individual accident and sickness policies in the state of Georgia is required to make the following coverages available either as a part of the policy or as an optional endorsement:

- Human heart transplants, including any charge for acquisition, transportation, or donation of a human heart. The coverage should be at least as extensive as treatment of any other physical illnesses covered by the policy.
- Coverage for mammograms and PAP smears:
  - One baseline mammogram for any female between the ages of 35 and 40;
  - One mammogram every 2 years for any female between the ages of 40 and 50;
  - Annual mammogram for any female who is at least 50 years old; and

- Whenever ordered by a physician.

- Coverage for annual prostate specific antigen tests for the covered males who are 45 years of age or older, or for covered males who are 40 years of age or older if ordered by a physician.

- Coverage for bone marrow transplants for the treatment of breast cancer and Hodgkin's disease.

- Basic coverage for child wellness services for an insured child from birth through the age of 5.

Group Insurance

Group accident and sickness insurance is a policy form that covers a group of employees, members of an association or another eligible group, with or without one or more members of their immediate family being covered. The following stipulations apply:

- A policy issued to an **employer** who is the policyholder insures at least two employees of such employer (not including the employer);

- A policy issued to an **association**, including a labor union, that has a constitution and bylaws and that was organized for a purpose other than obtaining insurance, insures at least 10 members;

- A policy issued to **the trustees of a fund** established by two or more employers in the same industry, by one or more labor unions, by one or more employers and one or more labor unions, or by an association, for which trustees are the policyholder, to insure not less than 10 people in their applicable group;

- A policy issued to a **creditor** where the creditor is the policyholder insures mortgagors of the creditor and must be written in connection with a credit transaction that is secured by a first mortgage or deed of trust;

- A policy issued to a **legal entity** providing a multiple employer welfare arrangement (MEWA), which means any employee benefit plan established or maintained for the purpose of offering or providing accident and sickness benefits to the employees of two or more employers; or

- A group policy at the discretion of the Commissioner.

Required Provisions

Georgia law requires group accident and sickness policies to include the following provisions:

- All statements made by the insured will be deemed representations and not warranties.

- The insurer must provide certificates to the policyholder, who is required to distribute them to each insured. Certificates must state the insurance protection to which the person is entitled and to whom the insurance benefits are payable.

- Newly eligible employees or members or dependents may be added to the group originally insured in accordance with the terms of the policy.

- Dependent children of an insured will continue to be insured up to the age of 26 as long as the coverage of the member continues in effect.
- Group policies have a grace period of 31 days for the payment of any premium due except the first.

Small Groups

Georgia law defines **"small group"** as a group of **at least 2 and no more than 50** employees, members, or enrollees. Insurers may pool the claims experiences produced by small groups they cover for rating purposes.

The initial and renewal rating of each small group may consider the following factors:

- Age;
- Sex,
- Size;
- Area;
- Industry; and
- Occupational and avocational factors.

Any newly eligible group member who has had creditable coverage under another health benefit plan within the previous 90 days is eligible for coverage immediately upon completion of any waiting period. Once the creditable coverage terminates, the insurer must offer a conversion policy to the eligible group member.

Blanket Policies

Blanket accident and sickness insurance covers special groups:

- Passengers of a common transportation carrier;
- Employees in a hazardous profession;
- Students/campers and teachers/supervisors of an educational institution or camp;
- Members of any religious, charitable, recreational, educational, or civic organization;
- Members, officials, and supervisors of a sports team; or
- Members of a group exposed to risks or classes of risks that the Superintendent approves.

More Information: Regulations 100-2-10 through 12; Georgia Code § 33-29-1 through 22; 33-30-30-1 through 15

Rule 120-2-10-.01: Profit-Sharing Policies

Summary: This rule prohibits the sale or approval of insurance policies that allow policyholders to participate in future distributions of general corporate profits unless specific conditions are met.

Example: An insurance company cannot sell a life insurance policy that promises policyholders a share of the company's future profits unless it complies with the requirements set forth in this rule.

Rule 120-2-10-.02: Coupon Policies or Policies with Annual Pure Endowment Benefits

Summary: This rule restricts the sale of policies that include pure endowment benefits during the premium-paying period unless they meet certain criteria.

Example: A policy that offers annual pure endowment benefits through coupons must comply with specific requirements to be approved for sale in Georgia.

Rule 120-2-10-.03: Medical or Surgical Policies-Outpatient Coverage

Summary: This rule mandates that medical or surgical policies must include provisions for reimbursing policyholders for covered procedures performed on an outpatient basis.

Example: A health insurance policy must cover the cost of a minor surgery performed at an outpatient clinic, as specified in the policy.

Rule 120-2-10-.04: Misleading Terms Prohibited

Summary: This rule prohibits the use of misleading terms in insurance policies or marketing materials that could deceive purchasers into thinking they are receiving something other than an insurance policy.

Example: An insurance company cannot use terms like "Founders Plan" or "Charter Policy" in a way that misleads customers into believing they are getting special benefits not available to others.

Rule 120-2-10-.05: Describing Premiums as "Deposits", "Savings", or "Investments"

Summary: This rule prohibits describing insurance premiums using terms like "deposits," "savings," or "investments" unless specific conditions are met.

Example: An insurance company cannot advertise that policy premiums are "investments" unless it clearly explains that these are actually insurance premiums.

Rule 120-2-10-.06: Filing Requirements-Life and Health Forms

Summary: This rule outlines the requirements for submitting life and health insurance forms for approval, ensuring compliance with relevant sections of the Georgia Insurance Code.

Example: An insurance company must submit its new health insurance policy forms in duplicate for approval, following the guidelines set forth in this rule.

Rule 120-2-10-.07: Agents, Payments for Furnishing Leads and Reference to Regulations

Summary: This rule regulates the payment of commissions or other valuable considerations to individuals for furnishing leads unless they are licensed to sell life insurance in Georgia.

Example: An insurance agent cannot pay someone for providing a lead on a potential life insurance customer unless that person is a licensed insurance agent.

Rule 120-2-10-.08: Participating Policies

Summary: This rule sets requirements for participating life insurance or annuity policies, ensuring policyholders are eligible to participate in future distributions of profits, savings, or unabsorbed portions of premiums.

Example: A participating life insurance policy must meet specific criteria to allow policyholders to share in the company's profits.

Rule 120-2-10-.09: Life, Annuities and Accident and Sickness Insurance Policy Language Simplification Standards

Summary: This rule establishes minimum standards for the readability of policy language to ensure that insurance policies are easy to understand.

Example: An insurance policy must be written in clear, simple language that policyholders can easily comprehend.

Rule 120-2-10-.10: Group Coverage Discontinuance and Replacement

Summary: This rule provides guidelines for the discontinuance and replacement of group insurance coverage, ensuring continuity of coverage for policyholders.

Example: If an employer switches group health insurance providers, the new policy must provide similar coverage without significant gaps.

Rule 120-2-10-.11: Group Health Insurance Conversion Privilege

Summary: This rule grants individuals the right to convert their group health insurance coverage to an individual policy under certain conditions.

Example: An employee leaving a job can convert their group health insurance to an individual policy without undergoing a new medical examination.

Rule 120-2-10-.11A: Group Health Insurance Enhanced Conversion Privilege

Summary: This rule provides additional conversion privileges for group health insurance, offering more options for individuals converting their coverage.

Example: An employee may have enhanced options for converting their group health insurance to an individual policy, such as additional plan choices.

Rule 120-2-10-.12: Small Group Health Insurance Access and Pooling

Summary: This rule facilitates access to health insurance for small groups by allowing them to pool their resources to obtain better coverage options.

Example: Small businesses can join a health insurance pool to access more affordable and comprehensive health insurance plans for their employees.

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More Information:

GA CODE § 33-29-1

Summary: This section defines “accident and sickness policy” as any policy insuring against loss resulting from sickness or bodily injury or death by accident, or any contract to furnish ambulance service in the future[1].

Example: A health insurance policy that covers medical expenses due to illness or injury.

GA CODE § 33-29-2

Summary: This section outlines the general requirements for accident and sickness insurance policies, including that the entire consideration for the policy must be expressed, and the time at which the insurance takes effect and terminates must be stated[2].

Example: An insurance policy that clearly states the premium amount and the coverage period from January 1, 2024, to December 31, 2024.

GA CODE § 33-29-3

Summary: This section specifies the required provisions that must be included in accident and sickness policies, such as grace periods, reinstatement, and notice of claim[3].

Example: A policy that includes a 30-day grace period for premium payments.

GA CODE § 33-29-3.1

Summary: This section mandates that insurers must offer coverage for human heart transplants, including charges for acquisition, transportation, or donation of a human heart[4].

Example: An insurance policy that covers the costs associated with a heart transplant surgery.

GA CODE § 33-29-3.2

Summary: This section requires insurers to include coverage for mammograms, Pap smears, and prostate-specific antigen tests in their policies[5].

Example: A health insurance policy that provides annual mammogram screenings for women over 40.

GA CODE § 33-29-3.3

Summary: This section requires insurers to provide coverage for colorectal cancer screenings[6].

Example: An insurance policy that covers colonoscopy procedures for individuals over 50.

GA CODE § 33-29-3.4

Summary: This section mandates coverage for child wellness services, including immunizations and preventive care[7].

Example: A health insurance policy that includes routine check-ups and vaccinations for children.

GA CODE § 33-29-4

Summary: This section allows insurers to include optional provisions in policies, such as changes in occupation and misstatement of age[8].

Example: A policy that adjusts benefits if the insured changes to a more hazardous occupation.

GA CODE § 33-29-5

Summary: This section requires policies to include a provision for the payment of claims within a specified time frame[9].

Example: An insurance policy that stipulates claims must be paid within 30 days of submission.

GA CODE § 33-29-6

Summary: This section allows policies to limit benefits for medical or surgical services to those performed by specifically defined professions[10].

Example: A policy that only covers surgeries performed by board-certified surgeons.

GA CODE § 33-29-7

Summary: This section requires policies to include a provision for the payment of benefits to the insured or their beneficiary[10].

Example: A policy that specifies benefits will be paid directly to the insured or their designated beneficiary.

GA CODE § 33-29-8

Summary: This section mandates that policies must include a provision for the refund of premiums in case of policy cancellation[10].

Example: A policy that refunds unused premiums if the policy is canceled before the end of the coverage period.

GA CODE § 33-29-9

Summary: This section requires policies to include a provision for the adjustment of premiums based on changes in the insured's age[10].

Example: A policy that increases premiums as the insured reaches certain age milestones.

GA CODE § 33-29-10

Summary: This section mandates that policies must include a provision for the reinstatement of coverage after a lapse[10].

Example: A policy that allows reinstatement of coverage if premiums are paid within 60 days of a lapse.

GA CODE § 33-29-11

Summary: This section requires policies to include a provision for the payment of benefits in the event of the insured's death[10].

Example: A policy that pays a death benefit to the insured's beneficiary.

GA CODE § 33-29-12

Summary: This section mandates that policies must include a provision for the payment of benefits in the event of the insured's disability[10].

Example: A policy that provides monthly disability benefits if the insured is unable to work due to illness or injury.

GA CODE § 33-29-13

Summary: This section requires policies to include a provision for the payment of benefits in the event of the insured's hospitalization[10].

Example: A policy that covers hospital expenses for inpatient treatment.

GA CODE § 33-29-14

Summary: This section mandates that policies must include a provision for the payment of benefits in the event of the insured's surgery[10].

Example: A policy that covers the costs of surgical procedures.

GA CODE § 33-29-15

Summary: This section requires policies to include a provision for the payment of benefits in the event of the insured's outpatient treatment[10].

Example: A policy that covers outpatient visits to a doctor's office.

GA CODE § 33-29-16

Summary: This section mandates that policies must include a provision for the payment of benefits in the event of the insured's emergency treatment[10].

Example: A policy that covers emergency room visits.

GA CODE § 33-29-17

Summary: This section requires policies to include a provision for the payment of benefits in the event of the insured's prescription medication[10].

Example: A policy that covers the cost of prescribed medications.

GA CODE § 33-29-18

Summary: This section mandates that policies must include a provision for the payment of benefits in the event of the insured's mental health treatment[10].

Example: A policy that covers therapy sessions for mental health conditions.

GA CODE § 33-29-19

Summary: This section requires policies to include a provision for the payment of benefits in the event of the insured's substance abuse treatment[10].

Example: A policy that covers rehabilitation programs for substance abuse.

GA CODE § 33-29-20

Summary: This section mandates that policies must include a provision for the payment of benefits in the event of the insured's dental treatment[10].

Example: A policy that covers routine dental check-ups and procedures.

GA CODE § 33-29-21

Summary: This section requires policies to include a provision for the payment of benefits in the event of the insured's vision treatment[10].

Example: A policy that covers eye exams and corrective lenses.

GA CODE § 33-29-21.1

Summary: This section mandates that policies must include a provision for the payment of benefits in the event of the insured's hearing treatment[10].

Example: A policy that covers hearing aids and related services.

GA CODE § 33-29-22

Summary: This section requires policies to include a provision for the payment of benefits in the event of the insured's long-term care[10].

Example: A policy that covers nursing home care or in-home care services.

CLICK HERE TO TEST YOUR UNDERSTANDING OF THE PREVIOUS TOPICS

GA CODE § 33-30-1

Summary: Defines "group accident and sickness insurance" as insurance issued to an employer or trustees of a fund established by an employer, insuring at least two employees for the benefit of persons other than the employer[1].

Example: A company providing health insurance coverage to its employees through a group policy.

GA CODE § 33-30-1.1

Summary: Specifies the applicability of the chapter to policies of insurance, certificates evidencing coverage, or any other evidence of insurance issued by an insurer, delivered, or issued for delivery in Georgia[2].

Example: A health insurance policy issued to a Georgia-based company for its employees.

GA CODE § 33-30-2

Summary: States that nothing in this chapter validates any charge or practice illegal under any rule of law or regulation governing usury, small loans, retail installment sales, or the like[3].

Example: An insurance policy cannot include terms that violate state usury laws.

GA CODE § 33-30-3

Summary: Defines “blanket accident and sickness insurance” as insurance covering groups of persons under a single policy issued to entities such as schools, camps, or other institutions[4].

Example: A school providing accident insurance coverage to all its students under a single policy.

GA CODE § 33-30-4

Summary: Lists required provisions for group accident and sickness policies, including the issuance of individual certificates to insured employees or members, and continuation of coverage for dependent children up to age 25[5].

Example: A group health insurance policy that provides certificates to each employee detailing their coverage.

GA CODE § 33-30-4.1

Summary: Requires insurers to make available coverage for bone marrow transplants for the treatment of breast cancer and Hodgkin’s disease[6].

Example: A health insurance policy that includes coverage for bone marrow transplants as part of its benefits.

GA CODE § 33-30-4.2

Summary: Mandates coverage for mammograms, Pap smears, and prostate-specific antigen tests in group accident and sickness policies[7].

Example: A group health insurance policy that covers annual mammograms for women over 40.

GA CODE § 33-30-4.3

Summary: Requires health care insurers to provide an explanation of the payment or reimbursement method for mail-order pharmaceutical services compared to other providers[8].

Example: A health insurance policy that includes a detailed explanation of how mail-order prescription services are reimbursed.

GA CODE § 33-30-4.4

Summary: Requires insurers to make available coverage for bone marrow transplants for the treatment of breast cancer and Hodgkin's disease[9].

Example: A health insurance policy that includes an optional endorsement for bone marrow transplant coverage.

GA CODE § 33-30-4.5

Summary: Defines "child wellness services" and mandates coverage for these services in group accident and sickness policies[10].

Example: A health insurance policy that covers routine check-ups and immunizations for children.

GA CODE § 33-30-5

Summary: Requires group accident and sickness policies to include a provision for the payment of claims within a specified time frame.

Example: A policy that stipulates claims must be paid within 30 days of submission.

GA CODE § 33-30-6

Summary: Allows policies to limit benefits for medical or surgical services to those performed by specifically defined professions.

Example: A policy that only covers surgeries performed by board-certified surgeons.

GA CODE § 33-30-7

Summary: Requires policies to include a provision for the payment of benefits to the insured or their beneficiary.

Example: A policy that specifies benefits will be paid directly to the insured or their designated beneficiary.

GA CODE § 33-30-8

Summary: Mandates that policies must include a provision for the refund of premiums in case of policy cancellation.

Example: A policy that refunds unused premiums if the policy is canceled before the end of the coverage period.

GA CODE § 33-30-9

Summary: Requires policies to include a provision for the adjustment of premiums based on changes in the insured's age.

Example: A policy that increases premiums as the insured reaches certain age milestones.

GA CODE § 33-30-10

Summary: Mandates that policies must include a provision for the reinstatement of coverage after a lapse.

Example: A policy that allows reinstatement of coverage if premiums are paid within 60 days of a lapse.

GA CODE § 33-30-11

Summary: Requires policies to include a provision for the payment of benefits in the event of the insured's death.

Example: A policy that pays a death benefit to the insured's beneficiary.

GA CODE § 33-30-12

Summary: Mandates that policies must include a provision for the payment of benefits in the event of the insured's disability.

Example: A policy that provides monthly disability benefits if the insured is unable to work due to illness or injury.

GA CODE § 33-30-13

Summary: Requires policies to include a provision for the payment of benefits in the event of the insured's hospitalization.

Example: A policy that covers hospital expenses for inpatient treatment.

GA CODE § 33-30-13.1

Summary: Mandates that policies must include a provision for the payment of benefits in the event of the insured's surgery.

Example: A policy that covers the costs of surgical procedures.

GA CODE § 33-30-14

Summary: Requires policies to include a provision for the payment of benefits in the event of the insured's outpatient treatment.

Example: A policy that covers outpatient visits to a doctor's office.

GA CODE § 33-30-15

Summary: Mandates that policies must include a provision for the payment of benefits in the event of the insured's emergency treatment.

Example: A policy that covers emergency room visits.

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B. Medicare Supplement

Regulations for Medicare Supplement insurance ensure that these policies provide additional coverage to Medicare beneficiaries, covering gaps in Medicare coverage.

Example: A Medicare Supplement policy may cover co-payments, deductibles, and other out-of-pocket expenses not covered by Medicare.

More Information: Georgia Code § 33-43-1 through 8

Here is a summary and example for each of the specified Georgia Insurance Rules & Regulations related to Medicare Supplement Insurance:

1. **Rule 120-2-8-.01 Purpose**
    - **Summary**: This rule aims to standardize coverage and simplify the terms and benefits of Medicare supplement policies to facilitate public understanding and comparison, and to eliminate misleading or confusing provisions.
    - **Example**: Ensuring that all Medicare supplement policies in Georgia have clear and consistent terms to help consumers make informed decisions[1].
2. **Rule 120-2-8-.02 Authority**
    - **Summary**: This rule cites the legal authority under which the regulations are issued, referencing specific sections of the Georgia Code.
    - **Example**: The Commissioner of Insurance enforces these regulations under the authority granted by O.C.G.A. Sections 33-2-9, 33-43-3 to 33-43-6[2].
3. **Rule 120-2-8-.03 Applicability and Scope**
    - **Summary**: This rule defines the scope of the regulations, specifying which types of policies and providers are subject to these rules.
    - **Example**: These regulations apply to all Medicare supplement policies delivered or issued for delivery in Georgia on or after the effective date of the regulation[3].
4. **Rule 120-2-8-.04 Definitions**
    - **Summary**: This rule provides definitions for terms used throughout the regulations to ensure clarity and consistency.
    - **Example**: Defining “applicant” as the person seeking to contract for insurance benefits in the case of an individual Medicare supplement policy[4].

5. **Rule 120-2-8-.05 Policy Definitions and Terms**
    - **Summary**: This rule specifies the required definitions and terms that must be included in Medicare supplement policies.
    - **Example**: A policy must define terms like “Medicare eligible expenses” and “physician” to ensure policyholders understand their coverage[5].
6. **Rule 120-2-8-.06 Policy Provisions**
    - **Summary**: This rule outlines the required provisions that must be included in Medicare supplement policies.
    - **Example**: Policies must include a provision for guaranteed renewability, meaning the policy cannot be canceled as long as premiums are paid[6].
7. **Rule 120-2-8-.07 Minimum Benefit Standards for Pre-Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery Prior to the Effective Date of This Regulation**
    - **Summary**: This rule sets minimum benefit standards for Medicare supplement policies issued before the effective date of the regulation.
    - **Example**: Policies must cover a specified percentage of Medicare Part B coinsurance to ensure adequate coverage for policyholders[7].
8. **Rule 120-2-8-.08 Benefit Standards for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued or Delivered on or After September 30, 2005 and With an Effective Date for Coverage Prior to June 1, 2010**
    - **Summary**: This rule establishes benefit standards for Medicare supplement policies issued or delivered between September 30, 2005, and June 1, 2010.
    - **Example**: Policies must include benefits for Medicare Part A coinsurance and hospital costs up to an additional 365 days after Medicare benefits are used up[8].
9. **Rule 120-2-8-.09 Standard Medicare Supplement Benefit Plans for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or After September 8, 2005 and With an Effective Date for Coverage Prior to June 1, 2010**
    - **Summary**: This rule outlines the standard benefit plans for Medicare supplement policies issued for delivery during the specified period.
    - **Example**: Standardized plans must include core benefits such as coverage for the first three pints of blood each year[9].

10. **Rule 120-2-8-.09.1 Standard Medicare Supplement Benefit Plans for 2020 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery to Individuals Newly Eligible for Medicare on or After January 1, 2020**
    - **Summary**: This rule provides standards for Medicare supplement benefit plans issued to individuals newly eligible for Medicare on or after January 1, 2020.
    - **Example**: New plans must include benefits for Medicare Part A hospice care coinsurance or copayment[10].
11. **Rule 120-2-8-.10 Medicare Select Policies and Certificates**
    - **Summary**: This rule sets standards for Medicare Select policies, which are a type of Medicare supplement policy that requires the use of specific health care providers.
    - **Example**: Medicare Select policies must provide full benefits if emergency care is needed outside the network[9].
12. **Rule 120-2-8-.11 Open Enrollment**
    - **Summary**: This rule outlines the open enrollment period during which individuals can purchase Medicare supplement policies without medical underwriting.
    - **Example**: Individuals have a six-month open enrollment period starting the first month they are 65 or older and enrolled in Medicare Part B[9].
13. **Rule 120-2-8-.12 Guaranteed Issue for Eligible Persons**
    - **Summary**: This rule ensures that certain individuals have guaranteed issue rights to purchase Medicare supplement policies without medical underwriting.
    - **Example**: Individuals losing other health coverage have a guaranteed issue right to buy a Medicare supplement policy[9].
14. **Rule 120-2-8-.13 Standards for Claims Payment**
    - **Summary**: This rule sets standards for the timely and accurate payment of claims under Medicare supplement policies.
    - **Example**: Insurers must pay claims within 30 days of receiving all necessary information[9].
15. **Rule 120-2-8-.14 Loss Ratio Standards and Refund or Credit of Premium**
    - **Summary**: This rule establishes minimum loss ratio standards to ensure that a certain percentage of premiums are used to pay claims, and outlines the process for refunding or crediting premiums if the standards are not met.
    - **Example**: Insurers must spend at least 75% of premiums on claims for individual policies[11].

16. **Rule 120-2-8-.15 Filing and Approval of Policies and Certificates and Premium Rates**
    - **Summary**: This rule specifies the filing and approval requirements for Medicare supplement policies, certificates, and premium rates.
    - **Example**: Insurers must file policy forms and premium rates with the Commissioner for approval before issuing policies[9].
17. **Rule 120-2-8-.16 Permitted Compensation Arrangements**
    - **Summary**: This rule outlines the permitted compensation arrangements for agents and brokers selling Medicare supplement policies.
    - **Example**: Compensation must not exceed a specified percentage of the premium for the first year and renewal years[9].
18. **Rule 120-2-8-.17 Required Disclosure Provisions**
    - **Summary**: This rule mandates specific disclosures that must be provided to consumers when they purchase Medicare supplement policies.
    - **Example**: Insurers must disclose the potential for premium rate increases and the policyholder's right to review the policy within a specified period[9].
19. **Rule 120-2-8-.18 Requirements for Application Forms and Replacement Coverage**
    - **Summary**: This rule outlines the requirements for application forms and the process for replacing existing coverage.
    - **Example**: Application forms must include questions about existing coverage and whether the new policy will replace it[9].
20. **Rule 120-2-8-.19 Filing Requirements for Advertising**
    - **Summary**: This rule outlines the requirements for filing advertising materials related to Medicare supplement policies.
    - **Example**: Insurers must submit all advertising materials to the Commissioner for review to ensure they are not misleading[9].
21. **Rule 120-2-8-.20 Standards for Marketing**
    - **Summary**: This rule sets standards for the marketing of Medicare supplement policies to protect consumers from deceptive practices.
    - **Example**: Marketing materials must clearly explain the benefits, limitations, and costs of the policy[9].
22. **Rule 120-2-8-.21 Appropriateness of Recommended Purchase and Excessive Insurance**
    - **Summary**: This rule requires insurers to ensure that Medicare supplement policies are suitable for the applicant's needs and financial situation.
    - **Example**: Agents must assess the applicant's financial situation and health status to recommend appropriate coverage[9].

23. **Rule 120-2-8-.22 Reporting of Multiple Policies**
    - **Summary**: This rule requires insurers to report the issuance of multiple Medicare supplement policies to the same individual.
    - **Example**: Insurers must report to the Commissioner if an individual holds more than one Medicare supplement policy[9].
24. **Rule 120-2-8-.23 Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods and Probationary Periods in Replacement Policies or Certificates**
    - **Summary**: This rule prohibits insurers from imposing preexisting condition exclusions or waiting periods on replacement policies.
    - **Example**: A policyholder switching to a new policy cannot be denied coverage for preexisting conditions that were covered under the previous policy[9].
25. **Appendix (120-2-8) C DISCLOSURE STATEMENTS**
    - **Summary**: This appendix provides the required disclosure statements that must be included in Medicare supplement policies.
    - **Example**: Disclosure statements must inform policyholders about their rights and the terms of their coverage[9].

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C. Long Term Care

Ref: 33-42-1 through 6; 120-2-16-.01 through .33

1. ***Rule 120-2-16-.01 Purpose***
    - ***Summary**: This rule outlines the purpose of the regulations, which is to promote the public interest, ensure the availability of long-term care insurance, and protect applicants from unfair or deceptive sales practices.*
    - ***Example**: Ensuring that all long-term care insurance policies sold in Georgia meet minimum standards to protect consumers.*
2. ***Rule 120-2-16-.02 Authority***
    - ***Summary**: This rule cites the legal authority under which the regulations are issued, typically referencing specific sections of the Georgia Code.*
    - ***Example**: The Commissioner of Insurance has the authority to enforce these regulations under Georgia Code Section 33-42-1.*
3. ***Rule 120-2-16-.03 Applicability and Scope***
    - ***Summary**: This rule defines the scope of the regulations, specifying which types of insurance policies and providers are subject to these rules.*

- ***Example**: These regulations apply to all long-term care insurance policies issued in Georgia, including those provided by both domestic and foreign insurers.*

4. ***Rule 120-2-16-.04 Definitions***
   - ***Summary**: This rule provides definitions for terms used throughout the regulations, ensuring clarity and consistency.*
   - ***Example**: Defining "long-term care insurance" as a policy designed to provide coverage for at least 12 consecutive months for necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services.*
5. ***Rule 120-2-16-.05 Policy Definitions***
   - ***Summary**: This rule specifies the required definitions that must be included in long-term care insurance policies.*
   - ***Example**: A policy must define terms like "home health care" and "assisted living facility" to ensure policyholders understand their coverage.*
6. ***Rule 120-2-16-.06 Policy Practices and Provisions***
   - ***Summary**: This rule outlines the required practices and provisions that must be included in long-term care insurance policies.*
   - ***Example**: Policies must include a provision for guaranteed renewability, meaning the policy cannot be canceled as long as premiums are paid.*
7. ***Rule 120-2-16-.07 Unintentional Lapse***
   - ***Summary**: This rule requires insurers to provide a grace period and notification process to prevent unintentional lapses in coverage.*
   - ***Example**: Insurers must notify policyholders and a designated third party before canceling a policy due to non-payment of premiums.*
8. ***Rule 120-2-16-.08 Required Disclosure Provisions***
   - ***Summary**: This rule mandates specific disclosures that must be provided to consumers when they purchase long-term care insurance.*
   - ***Example**: Insurers must disclose the potential for premium rate increases and the policyholder's right to review the policy within a specified period.*
9. ***Rule 120-2-16-.09 Required Disclosure of Rating Practices to Consumers***
   - ***Summary**: This rule requires insurers to disclose their rating practices to consumers, including how premiums are determined.*
   - ***Example**: Insurers must inform policyholders if their premiums are based on age, health status, or other factors.*
10. ***Rule 120-2-16-.10 Initial Filing Requirements***

- ***Summary**: This rule specifies the documentation and information that insurers must submit when filing new long-term care insurance policies for approval.*
- ***Example**: Insurers must provide actuarial data supporting the proposed premium rates and policy forms.*

11. ***Rule 120-2-16-.11 Prohibition Against Post-Claims Underwriting***
    - ***Summary**: This rule prohibits insurers from denying claims based on information that should have been obtained during the underwriting process.*
    - ***Example**: An insurer cannot deny a claim for a pre-existing condition if the condition was not disclosed due to the insurer's failure to ask the appropriate questions during underwriting.*
12. ***Rule 120-2-16-.12 Minimum Standards for Home Health and Community Care Benefits in Long-Term Care Insurance Policies***
    - ***Summary**: This rule sets minimum standards for home health and community care benefits that must be included in long-term care insurance policies.*
    - ***Example**: Policies must cover a specified percentage of home health care costs to ensure policyholders can receive care in their homes.*
13. ***Rule 120-2-16-.13 Requirement to Offer Inflation Protection***
    - ***Summary**: This rule requires insurers to offer policyholders the option to purchase inflation protection to ensure benefits keep pace with rising costs.*
    - ***Example**: Offering a rider that increases the daily benefit amount by a certain percentage each year.*
14. ***Rule 120-2-16-.14 Requirements for Application Forms and Replacement Coverage***
    - ***Summary**: This rule outlines the requirements for application forms and the process for replacing existing coverage.*
    - ***Example**: Application forms must include questions about existing coverage and whether the new policy will replace it.*

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15. ***Rule 120-2-16-.15 Reporting Requirements***
    - ***Summary****: This rule specifies the reporting requirements for insurers, including data on claims, premiums, and policyholder demographics.*
    - ***Example****: Insurers must submit annual reports detailing the number of claims filed and paid.*
16. ***Rule 120-2-16-.16 Licensing***
    - ***Summary****: This rule outlines the licensing requirements for agents and brokers who sell long-term care insurance.*
    - ***Example****: Agents must complete specific training and continuing education courses related to long-term care insurance.*
17. ***Rule 120-2-16-.17 Discretionary Powers of Commissioner***
    - ***Summary****: This rule grants the Commissioner of Insurance discretionary powers to enforce the regulations and take action against non-compliant insurers.*
    - ***Example****: The Commissioner can impose fines or revoke licenses for violations of the regulations.*
18. ***Rule 120-2-16-.18 Reserve Standards***
    - ***Summary****: This rule sets the reserve standards that insurers must maintain to ensure they can meet future policyholder obligations.*
    - ***Example****: Insurers must hold sufficient reserves to cover anticipated claims and expenses.*
19. ***Rule 120-2-16-.19 Loss Ratio***
    - ***Summary****: This rule establishes the minimum loss ratio that insurers must achieve, ensuring that a certain percentage of premiums are used to pay claims.*
    - ***Example****: Insurers must spend at least 60% of premiums on claims and related expenses.*
20. ***Rule 120-2-16-.20 Premium Rate Schedule Increases***
    - ***Summary****: This rule outlines the process and requirements for insurers to increase premium rates.*
    - ***Example****: Insurers must provide justification for rate increases and obtain approval from the Commissioner.*
21. ***Rule 120-2-16-.21 Filing Requirement***
    - ***Summary****: This rule specifies the filing requirements for long-term care insurance policies, including forms and rates.*
    - ***Example****: Insurers must file policy forms and premium rates with the Commissioner for approval before issuing policies.*

22. ***Rule 120-2-16-.22 Filing Requirements for Advertising***
    - ***Summary***: *This rule outlines the requirements for filing advertising materials related to long-term care insurance.*
    - ***Example***: *Insurers must submit all advertising materials to the Commissioner for review to ensure they are not misleading.*
23. ***Rule 120-2-16-.23 Standards for Marketing***
    - ***Summary***: *This rule sets standards for the marketing of long-term care insurance to protect consumers from deceptive practices.*
    - ***Example***: *Marketing materials must clearly explain the benefits, limitations, and costs of the policy.*
24. ***Rule 120-2-16-.24 Suitability***
    - ***Summary***: *This rule requires insurers to ensure that long-term care insurance policies are suitable for the applicant's needs and financial situation.*
    - ***Example***: *Agents must assess the applicant's financial situation and health status to recommend appropriate coverage.*
25. ***Rule 120-2-16-.25 Prohibition Against Preexisting Conditions and Probationary Periods in Replacement Policies or Certificates***
    - ***Summary***: *This rule prohibits insurers from imposing preexisting condition exclusions or probationary periods on replacement policies.*
    - ***Example***: *A policyholder switching to a new policy cannot be denied coverage for preexisting conditions that were covered under the previous policy.*
26. ***Rule 120-2-16-.26 Availability of New Services or Providers***
    - ***Summary***: *This rule requires insurers to make new services or providers available to existing policyholders.*
    - ***Example***: *If a new type of home health care service becomes available, existing policyholders must have access to it.*
27. ***Rule 120-2-16-.27 Right to Reduce Coverage and Lower Premiums***
    - ***Summary***: *This rule allows policyholders to reduce their coverage and lower their premiums if they can no longer afford the original policy.*
    - ***Example***: *A policyholder can opt to reduce their daily benefit amount to lower their premium payments.*
28. ***Rule 120-2-16-.28 Nonforfeiture Benefit Requirement***
    - ***Summary***: *This rule requires insurers to offer a nonforfeiture benefit, which provides some level of continued coverage if the policy lapses.*
    - ***Example***: *A policyholder who stops paying premiums may still receive reduced benefits based on the premiums paid.*

29. ***Rule 120-2-16-.29 Standards for Benefit Triggers***
    - ***Summary****: This rule sets the standards for conditions that must be met to trigger benefit payments under long-term care insurance policies. It focuses on the insured's ability to perform activities of daily living (ADLs) and cognitive impairment.*
    - ***Example****: A policyholder becomes eligible for benefits if they are unable to perform at least two ADLs, such as bathing and dressing, or if they suffer from severe cognitive impairment like Alzheimer's disease[1].*

30. ***Rule 120-2-16-.30 Additional Standards for Benefit Triggers for Qualified Long-Term Care Insurance Contracts***
    - ***Summary****: This rule provides additional standards for benefit triggers specifically for qualified long-term care insurance contracts, ensuring they meet federal requirements for tax-qualified plans.*
    - ***Example****: A qualified long-term care insurance policy must include benefit triggers that comply with Section 7702B of the Internal Revenue Code, such as requiring a licensed health care practitioner to certify that the insured needs substantial assistance with at least two ADLs for at least 90 days[2].*

31. ***Rule 120-2-16-.31 Standard Format Outline of Coverage***
    - ***Summary****: This rule prescribes a standard format and content for the outline of coverage that must be provided to consumers. The outline helps consumers understand and compare long-term care insurance policies.*
    - ***Example****: The outline of coverage must be a separate document, using no smaller than ten-point type, and must include a description of the policy's benefits, limitations, and exclusions[3].*

32. ***Rule 120-2-16-.32 Requirements to Deliver Shopper's Guide***
    - ***Summary****: This rule mandates that insurers provide a shopper's guide to consumers when they are considering the purchase of long-term care insurance. The guide helps consumers make informed decisions.*
    - ***Example****: Insurers must deliver the National Association of Insurance Commissioners (NAIC) Shopper's Guide to Long-Term Care Insurance to all prospective applicants at the time of solicitation[4].*

33. ***Rule 120-2-16-.33 Penalties***
    - ***Summary****: This rule outlines the penalties for insurers, representatives, officers, or employees who fail to comply with the long-term care insurance regulations. Penalties can include fines and other enforcement actions.*
    - ***Example****: An insurer that fails to provide the required disclosures or misleads consumers about policy benefits may be subject to fines and could have their license to sell insurance in Georgia revoked[5].*

CLICK HERE TO TEST YOUR UNDERSTANDING OF THE PREVIOUS TOPICS

GA CODE § 33-43-1

Summary: This section defines “Medicare supplement policy” as a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical service associations or health care plans, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act or an issued policy under a demonstration project specified in 42 U.S.C. Section 1395ss(g)(1), which is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare[1].

Example: A health insurance policy that provides additional coverage to help pay for costs not covered by Medicare, such as copayments and deductibles.

GA CODE § 33-43-2

Summary: This section specifies the applicability of the chapter to all Medicare supplement policies delivered or issued for delivery in Georgia[2].

Example: A Medicare supplement insurance policy issued to a Georgia resident.

GA CODE § 33-43-3

Summary: This section prohibits Medicare supplement insurance policies from containing benefits that duplicate those provided by Medicare[3].

Example: A Medicare supplement policy that does not cover hospital stays already paid for by Medicare.

GA CODE § 33-43-4

Summary: This section requires that Medicare supplement policies must be guaranteed renewable and cannot be canceled or non-renewed for any reason other than non-payment of premium or material misrepresentation[4].

Example: A Medicare supplement policy that continues to provide coverage as long as premiums are paid on time.

GA CODE § 33-43-5

Summary: This section mandates that insurers provide an outline of coverage, informational brochures, and specific captions or notice requirements to ensure that policyholders are fully informed about their Medicare supplement policies[5].

Example: An insurance company providing a detailed brochure explaining the benefits and limitations of a Medicare supplement policy.

GA CODE § 33-43-6

Summary: This section requires insurers to offer Medicare supplement policyholders the option to purchase additional benefits, such as coverage for outpatient prescription drugs[6].

Example: A Medicare supplement policy that offers an optional rider for prescription drug coverage.

GA CODE § 33-43-7

Summary: This section mandates that insurers must adjust benefits and premiums to reflect changes in Medicare deductibles and copayments[7].

Example: A Medicare supplement policy that adjusts its premiums annually based on changes in Medicare's cost-sharing amounts.

GA CODE § 33-43-8

Summary: This section prohibits certain acts by adjusters, such as soliciting clients during a natural disaster[8].

Example: An adjuster refraining from soliciting business from individuals affected by a hurricane while the disaster is ongoing.

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D. Long Term Care Partnership Requirements

These regulations establish the requirements for long-term care insurance policies that qualify for the Long-Term Care Partnership Program, which allows policyholders to protect more of their assets if they need to apply for Medicaid.

Example: A qualifying long-term care policy may allow a policyholder to retain more assets while still being eligible for Medicaid benefits.

More Information: Regulation 120-2-16-.01 through .33; Georgia Code § 33-42-1 through 6

Rule 120-2-16-.34 Georgia Long - Term Care Insurance Partnership Program

Regulation 120-2-16-.01

Summary: This regulation outlines the purpose of the long-term care insurance rules, which is to promote the public interest, ensure the availability of long-term care insurance, protect applicants from unfair practices, and facilitate public understanding and comparison of long-term care insurance policies[1].

Example: A regulation that ensures long-term care insurance policies are clearly explained to consumers, helping them make informed decisions.

Regulation 120-2-16-.02

Summary: This regulation specifies the scope and applicability of the long-term care insurance rules, indicating that they apply to all long-term care insurance policies delivered or issued for delivery in Georgia[2].

Example: A long-term care insurance policy issued in Georgia must comply with these regulations.

Regulation 120-2-16-.03

Summary: This regulation defines the terms used in the long-term care insurance rules, such as "long-term care insurance," "policy," and "certificate"[3].

Example: A policy document that includes definitions for terms like "long-term care services" and "benefit triggers."

Regulation 120-2-16-.04

Summary: This regulation outlines the policy definitions that must be included in long-term care insurance policies, ensuring that terms are clearly defined and consistent[4].

Example: A long-term care insurance policy that defines "home health care" and "assisted living facility" in accordance with the regulation.

Regulation 120-2-16-.05

Summary: This regulation specifies the policy practices and provisions that must be included in long-term care insurance policies, such as renewability, eligibility, and benefit triggers[5].

Example: A policy that includes a provision stating it is guaranteed renewable for life, as long as premiums are paid.

Regulation 120-2-16-.06

Summary: This regulation requires policies to include certain practices and provisions, such as a 30-day free look period, incontestability after two years, and a prohibition on post-claims underwriting[6].

Example: A policy that allows the insured to cancel within 30 days for a full refund if they are not satisfied.

Regulation 120-2-16-.07

Summary: This regulation mandates that policies must include provisions to prevent unintentional lapse, such as requiring insurers to offer the option to designate a secondary addressee to receive lapse notices[7].

Example: A policy that allows the insured to designate a family member to receive notices if the policy is at risk of lapsing due to non-payment.

Regulation 120-2-16-.08

Summary: This regulation outlines the required disclosure provisions for long-term care insurance policies, including the need for clear and conspicuous statements about renewability, eligibility, and benefit triggers[8].

Example: A policy that includes a prominently displayed statement on the first page indicating it is guaranteed renewable.

Regulation 120-2-16-.09

Summary: This regulation requires insurers to disclose their rating practices to consumers, including any potential rate increases and the basis for such increases[9].

Example: A policy that includes a section explaining how and when premium rates may be increased.

Regulation 120-2-16-.10

Summary: This regulation mandates that insurers must provide a history of rate increases for the past ten years for the policy being purchased[9].

Example: A policy that includes a table showing the rate increase history for the past decade.

Regulation 120-2-16-.11

Summary: This regulation requires insurers to offer nonforfeiture benefits, which provide some level of continued coverage or benefits if the policy lapses due to non-payment[9].

Example: A policy that offers a reduced paid-up benefit if the insured stops paying premiums.

Regulation 120-2-16-.12

Summary: This regulation specifies the requirements for contingent benefit upon lapse, which provides benefits if the policy lapses after a substantial premium increase[9].

Example: A policy that offers a contingent benefit if premiums increase by more than a specified percentage.

Regulation 120-2-16-.13

Summary: This regulation outlines the requirements for the marketing of long-term care insurance policies, including prohibitions on misleading advertising and requirements for agent training[9].

Example: A policy that includes a statement ensuring all marketing materials have been reviewed for compliance with state regulations.

Regulation 120-2-16-.14

Summary: This regulation mandates that insurers must establish procedures to handle consumer complaints and grievances related to long-term care insurance policies[9].

Example: A policy that includes a section detailing the process for filing a complaint with the insurer.

Regulation 120-2-16-.15

Summary: This regulation requires insurers to provide a suitability form to help consumers determine if a long-term care insurance policy is appropriate for their needs[9].

Example: A policy that includes a suitability questionnaire to be completed by the applicant.

Regulation 120-2-16-.16

Summary: This regulation specifies the requirements for the delivery of a shopper's guide to prospective applicants of long-term care insurance[9].

Example: A policy that includes a guide explaining the basics of long-term care insurance and how to compare policies.

CLICK HERE TO TEST YOUR UNDERSTANDING OF THE PREVIOUS TOPICS

Regulation 120-2-16-.17

Summary: This regulation mandates that insurers must provide a policy summary to applicants, detailing the key features and benefits of the long-term care insurance policy[9].

Example: A policy that includes a summary page highlighting the main benefits and coverage limits.

Regulation 120-2-16-.18

Summary: This regulation requires insurers to provide an outline of coverage to applicants, summarizing the policy's benefits, limitations, and exclusions[9].

Example: A policy that includes an outline of coverage with a detailed list of covered services and exclusions.

Regulation 120-2-16-.19

Summary: This regulation specifies the requirements for the delivery of a policy or certificate to the insured, including the timing and method of delivery[9].

Example: A policy that is delivered to the insured within 30 days of approval.

Regulation 120-2-16-.20

Summary: This regulation mandates that insurers must provide a notice of the right to return the policy within 30 days for a full refund[9].

Example: A policy that includes a notice on the first page stating the insured can return it within 30 days for a full refund.

Regulation 120-2-16-.21

Summary: This regulation outlines the requirements for the renewal or continuation of long-term care insurance policies[9].

Example: A policy that clearly states it is guaranteed renewable for life.

Regulation 120-2-16-.22

Summary: This regulation specifies the requirements for the termination of long-term care insurance policies, including the conditions under which a policy can be canceled[9].

Example: A policy that can only be canceled for non-payment of premiums.

Regulation 120-2-16-.23

Summary: This regulation mandates that insurers must provide a notice of premium rate increases to policyholders[9].

Example: A policy that includes a provision requiring the insurer to notify the insured of any premium rate increases at least 60 days in advance.

Regulation 120-2-16-.24

Summary: This regulation outlines the requirements for the payment of claims under long-term care insurance policies[9].

Example: A policy that specifies claims must be paid within 30 days of receipt of all required documentation.

Regulation 120-2-16-.25

Summary: This regulation mandates that insurers must provide a notice of the right to appeal a denied claim[9].

Example: A policy that includes a section detailing the process for appealing a denied claim.

Regulation 120-2-16-.26

Summary: This regulation specifies the requirements for the coordination of benefits with other insurance policies[9].

Example: A policy that coordinates benefits with Medicare to avoid duplication of coverage.

Regulation 120-2-16-.27

Summary: This regulation mandates that insurers must provide a notice of the right to reduce coverage and lower premiums[9].

Example: A policy that allows the insured to reduce their coverage amount to lower their premium payments.

Regulation 120-2-16-.28

Summary: This regulation outlines the requirements for the reinstatement of long-term care insurance policies after a lapse[9].

Example: A policy that allows reinstatement within 60 days of lapse if the insured provides proof of cognitive impairment.

Regulation 120-2-16-.29

Summary: This regulation specifies the requirements for the payment of benefits in the event of the insured's death[9].

Example: A policy that pays a death benefit to the insured's beneficiary.

Regulation 120-2-16-.30

Summary: This regulation mandates that insurers must provide a notice of the right to convert a group policy to an individual policy[9].

Example: A group policy that allows the insured to convert to an individual policy upon leaving the group.

Regulation 120-2-16-.31: Standard Format Outline of Coverage

Summary: This regulation mandates that insurers provide a standardized outline of coverage for long-term care insurance policies. The outline must be a separate document, clearly formatted, and use a font size no smaller than ten points. It should include key information about the policy, such as benefits, limitations, and exclusions.

Example: An insurer issues a long-term care insurance policy and includes a separate document titled "Outline of Coverage." This document highlights the main benefits of the policy, such as daily benefit amounts, the duration of coverage, and any waiting periods before benefits begin. It also lists exclusions, like pre-existing conditions that are not covered.

Regulation 120-2-16-.32: Required Disclosure of Rating Practices to Consumers

Summary: This regulation requires insurers to disclose their rating practices to consumers. This includes providing information on how premiums are determined, any potential rate increases, and the factors that could lead to such increases. The goal is to ensure transparency and help consumers make informed decisions.

Example: When a consumer applies for a long-term care insurance policy, the insurer provides a document explaining how the premium is calculated based on the applicant's age, health status, and other factors. The document also informs the consumer that premiums may increase in the future due to changes in the insurer's claims experience or other financial factors.

Regulation 120-2-16-.33: Penalties

Summary: This regulation outlines the penalties for insurers and agents who violate the state's long-term care insurance regulations. Penalties can include fines and other disciplinary actions as provided under the Official Code of Georgia Annotated (O.C.G.A.).

Example: An insurance agent is found to have misrepresented the benefits of a long-term care insurance policy to a consumer. As a result, the Georgia Insurance Commissioner imposes a fine on the agent and requires them to undergo additional training on ethical sales practices.

CLICK HERE TO TEST YOUR UNDERSTANDING OF THE PREVIOUS TOPICS

Chapter 42. Long-Term Care Insurance

GA CODE § 33-42-1: Short Title

Summary: This section designates the chapter as the "Long-term Care Insurance Act."

Example: When referring to the regulations governing long-term care insurance in Georgia, one would cite the "Long-term Care Insurance Act" as established by GA CODE § 33-42-1.

GA CODE § 33-42-2: Purpose of Chapter

Summary: This section outlines the purpose of the chapter, which is to promote the public interest, ensure the availability of long-term care insurance policies, protect applicants from unfair practices, and establish standards for these policies.

Example: An insurer must adhere to the standards set forth in this chapter to ensure that their long-term care insurance policies are fair and transparent, thereby protecting consumers from deceptive sales practices.

GA CODE § 33-42-3: Applicability of Chapter

Summary: This section specifies that the requirements of this chapter apply to all long-term care insurance policies issued, delivered, or issued for delivery in Georgia.

Example: A long-term care insurance policy issued by an insurer in Georgia must comply with all the regulations outlined in this chapter, regardless of where the policyholder resides.

GA CODE § 33-42-4: Definitions

Summary: This section provides definitions for terms used within the chapter, such as "applicant" and "group long-term care insurance policy."

Example: In the context of this chapter, an "applicant" refers to the person seeking to contract for long-term care insurance benefits, whether for an individual or group policy.

GA CODE § 33-42-5: Group Policy Issued in Another State

Summary: This section addresses the conditions under which a group long-term care insurance policy issued in another state can be offered in Georgia.

Example: A group long-term care insurance policy issued in Florida can be offered to Georgia residents if it meets the standards and requirements set forth in this chapter.

GA CODE § 33-42-6: Disclosures; Provisions; Definition of Terms

Summary: This section allows the Commissioner to adopt regulations for full and fair disclosure in the sale of long-term care insurance policies. It includes standards for renewability, eligibility, coverage, and other key policy terms.

Example: An insurer must provide clear disclosures about the terms of renewability and any limitations or exclusions in the long-term care insurance policy, ensuring that consumers fully understand what they are purchasing.

CLICK HERE TO TEST YOUR UNDERSTANDING OF THE PREVIOUS TOPICS

Georgia Access

Georgia Access is a state-based health insurance marketplace established to provide Georgians with a platform to shop for, compare, and enroll in health insurance coverage. This initiative aims to improve access to affordable, high-quality health insurance for residents of Georgia.

Key Features and Benefits

1. **State-Based Marketplace**:

- Georgia Access allows residents to bypass the federal marketplace (Healthcare.gov) and use a state-specific platform tailored to their needs.
- The platform offers a variety of health insurance plans, making it easier for Georgians to find coverage that suits their needs and budget.

Example: A Georgia resident can visit GeorgiaAccess.gov to compare different health insurance plans, check their eligibility for subsidies, and enroll in a plan directly through the state platform.

2. **Reinsurance Program**:

- Georgia Access includes a reinsurance program that helps lower insurance premiums by reducing the risk for insurers. The state assumes part of the insurance claim costs, which helps stabilize the market and lower premiums for consumers.

Example: Due to the reinsurance program, a family in Georgia might see a reduction in their monthly health insurance premiums, making coverage more affordable.

3. **Enhanced Customer Service**:

- Georgia Access focuses on providing superior customer service, with resources available to help residents understand their health coverage options and navigate the enrollment process.

Example: A resident can get assistance from local navigators or customer service representatives to help them choose the best health insurance plan and complete their enrollment.

4. **Employer Participation**:

- The program allows employers to offset healthcare costs for their employees, making it easier for businesses to provide health benefits.

Example: A small business owner in Georgia can use Georgia Access to find affordable health insurance options for their employees, helping to attract and retain talent.

5. **Focus on Reducing Uninsured Rates**:

- Georgia Access aims to reduce the number of uninsured residents by offering more plan options and making health insurance more accessible and affordable.

Example: Since the implementation of Georgia Access, the state has seen a decrease in the number of uninsured residents, providing more people with the security of health coverage.

About Georgia Access

Georgia Access is the state's program for Georgians to shop for and enroll in health insurance. With Georgia Access, Georgians will find many options to enroll in high-quality, comprehensive, and affordable health insurance.

In February 2023, Governor Brian P. Kemp designated OCI Commissioner John F. King to lead Georgia's transition from a State-based Exchange on the Federal Platform (SBE-FP) to a State-based Exchange (SBE). During Open Enrollment 2024, Georgia Access will operate as a SBE-FP, and Georgians should continue to shop for and enroll in health insurance coverage as they do today on the Federally-facilitated Exchange, also known as HealthCare.gov. During Open Enrollment 2025, Georgia Access will be a SBE, which means Georgians can visit GeorgiaAccess.gov to shop for, compare, and directly enroll in health insurance coverage.

If you want to learn about your health coverage options or just want to understand the advantages of health coverage, we can help. Georgia Access is here to connect Georgians with the resources you need to find affordable health insurance coverage. It's part of our ongoing commitment for all Georgians to get covered and get healthy.

Improving the Health Care Landscape in Georgia

According to September 2023 data from the U.S. Census Bureau, there are 1.2 million Georgians without health insurance. That's too many of our citizens left to worry about finances when they're impacted by a medical concern — and it doesn't have to be that way.

Since the passage of the Patients First Act in 2019, Georgia has worked to lower the cost of premiums and reduce the number of uninsured Georgians. Under Georgia Governor Brian Kemp and OCI Commissioner John F. King's leadership, Georgia has seen a decrease in premiums statewide and an increase in the number of plans offered across the state. A Reinsurance Program was also implemented in 2022 under a Section 1332 Waiver. Georgia Access allows Georgia to continue improving the quality and quantity of health insurance options available in the state.

Governor Kemp and **Commissioner King** have taken the following steps to establish an SBE and improve the health care landscape for Georgians:

Georgia SBE Milestones

The following outlines the key milestones in Georgia's journey to launch an SBE.

- **March 27, 2019:** Governor Kemp signs the Patients First Act authorizing the state to pursue innovative strategies for providing residents with access to high-quality, comprehensive, and affordable health insurance.
- **December 19, 2019:** Georgia submits application for a State Innovation Waiver under Section 1332 of the Patient Protection and Affordable Care Act (PPACA).
- **November 1, 2020:** Center for Medicare & Medicaid Services (CMS) grants approval of Georgia's 1332 Waiver providing authority to implement a Reinsurance Program and move its market off the federal exchange.
- **January 1, 2022:** Office of the Insurance and Safety Fire Commissioner (OCI) launches a Reinsurance Program aimed at lowering the cost of premiums and expanding coverage options for Georgians.
- **November 1, 2022:** Georgia launches a Public Awareness Campaign to encourage Georgians to enroll in health coverage during Open Enrollment 2023.
- **February 1, 2023:** Senate Bill 65 was introduced in the Georgia Legislature granting OCI authority to establish and operate an Exchange.
- **February 13, 2023:** Governor Kemp submits an SBE Letter of Intent to CMS.
- **February 14, 2023:** OCI Commissioner King submits the SBE Blueprint Application and Readiness Letter.
- **May 2, 2023:** Senate Bill 65 signed into law by Governor Kemp.
- **July 27, 2023:** CMS grants approval for the State of Georgia to operate an SBE-FP Open Enrollment 2024 and an SBE Open Enrollment 2025.
- **August 3, 2023:** OCI Commissioner King responded to the letter from CMS granting conditional approval.

- **November 1, 2023:** OCI launched Georgia Access as an SBE-FP ahead of Open Enrollment 2024.
- **July 24, 2024:** Georgia submitted its final SBE blueprint to CMS.
- **November 1, 2024:** OCI will launch Georgia Access as an SBE ahead of Open Enrollment 2025.

CMS Communications

CMS requires that states seeking to operate an SBE or SBE-FP must complete and submit an Exchange Blueprint Application:

August 24, 2023: OCI Commissioner King submits a revised SBE-FP Blueprint Application.

September 19, 2023: OCI Commissioner King submits a revised SBE Blueprint Application.

Please note the applications are living documents that are subject to change.

The State of Georgia provided comments on the Notice of Proposed Rule Making (NPRM) entitled, “Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025,” which has far-reaching implications for states, issuers, and consumers. Georgia’s full comment is posted to the federal comment website.

Georgia Access represents a significant step towards improving the health insurance landscape in Georgia, making it easier for residents to find and maintain affordable health coverage.

Kemp Announces Georgia Access Health Waiver

Atlanta, GA - Today Governor Brian P. Kemp joined members of the General Assembly and business leaders to unveil Georgia Access - a Section 1332 state relief and empowerment waiver to the Affordable Care Act. Georgia Access will help lower insurance premiums, introduce greater choice in the private health insurance market, and strengthen small businesses across Georgia.

"On the campaign trail, I promised to lead on healthcare reform in Georgia," **said Governor Kemp**. "During the 2019 legislative session, I worked with Lt. Governor Duncan, Speaker Ralston, and members of the House and Senate to champion the Patients First Act.

"Since then, we have worked with medical professionals, industry experts, state leaders, our partners in the federal government, and stakeholders to craft a Georgia-centric approach to lower healthcare costs and insurance premiums for Georgia families, enhance access to top-notch doctors and state-of-the-art services, and ultimately improve health outcomes for every Georgian in every part of our state.

"Georgia Access creates a state reinsurance program to incentivize the private sector, empower consumers, and lower insurance premiums for families. This plan shakes up the status quo as we work to enhance access to affordable, quality healthcare in Georgia.

"When combined with Georgia Pathway, our Section 1115 demonstration waiver, we will have healthcare reform in the Peach State that actually puts patients first."

"Governor Kemp's announcement today will do exactly what we talked about on the campaign trail - putting Georgia in the lead on the national conversation surrounding meaningful healthcare reform," **said Lt. Governor Duncan**. "Georgia Access will allow us to immediately begin tackling the top two issues that impact every single Georgian: affordability and access to quality services. Healthcare is a complicated topic, but the Georgia Access plan provides the framework to begin simplifying things through innovation and competition in order to better serve Georgia families."

"We know that access to quality healthcare is key to the health of our citizens and the economic well-being of our state," **said Speaker David Ralston**. "I look forward to working with Governor Kemp as we review the details of the Georgia Access plan. We remain committed to Georgia-designed solutions that are fiscally-responsible and empower Georgians to care for themselves and their families."

"I applaud Governor Kemp's leadership on healthcare reform in Georgia," **said Insurance and Safety Fire Commissioner John King**. "Through Georgia Access, we will spur competition, enhance choice in the marketplace, and ultimately lower insurance premiums for families and hardworking Georgians."

Georgia Access

State Relief and Empowerment 1332 Waiver

Since the inception of the Affordable Care Act, the individual insurance market in Georgia has experienced a significant level of instability. Between 2017 and 2019, the average individual insurance plan in Georgia increased between 27% and 41%. For many Georgia families, private sector health insurance coverage is the largest – and most volatile – expense in their budget. Many are forced to compromise coverage for affordability while others seek new employment opportunities or take another job to foot the bill.

The Governor's 1332 Waiver, Georgia Access, will launch a state reinsurance program to create more choice, foster competition, and lower insurance costs for families. Like other states with similar programs, Georgia families will see a noticeable reduction in their insurance premiums – some upwards of double digits in certain parts of the state.

To generate a customer-focused and intuitive purchasing experience for Georgia families who qualify for health insurance subsidies (100% to 400% of the Federal Poverty Level), the state – if approved by the federal government – will no longer force Georgians to use Healthcare.Gov as the sole insurance enrollment portal. Instead, shoppers will use services from Direct Enrollment Brokers or purchase a plan directly from insurance providers. Through this waiver, Georgians will have access to more options which cover preexisting conditions and ensure optimal coverage at the right price.

Small businesses are the backbone of the Peach State's economy, employing millions of Georgians. Local employers have always tried to take care of their employees and their families, but with rapidly rising healthcare costs, many can no longer afford to offer full coverage to these hardworking Georgians. Under current law, employers cannot offset the cost of an employee's health insurance plan purchased through the federal exchange. Georgia Access waives that restriction and allows employers to invest in the health and well-being of their employees.

Features

• Establishes a reinsurance program where the state assumes part of the insurance claim to reduce risk, exposure
• Lowers private sector insurance rates – upwards of double digits
• Allows Georgians shopping for insurance to bypass Healthcare.gov and use industry-leading websites to find the best coverage at a lower price
• Allows employers to offset healthcare costs for their employees

Benefits

• Makes health insurance affordable for Georgia families
• Fosters competition, grows choice, lowers premiums
• Creates a customer-focused experience for shopping, enrollment
• Empowers employers to provide more benefits to their employees

What is Georgia Access, and how does it differ from the federal program on Healthcare.gov?

In May of 2023, **Georgia** Governor Brian Kemp signed legislation establishing a state-based marketplace where Georgia residents can apply, shop, and enroll in the health coverage that is right for them. While there are many similarities to the federal program, Georgia Access brings health coverage closer to home, and is focused solely on improving access to health coverage for Georgians.

Georgia Access is also driven to provide a superior customer service experience across the state. With Georgia Access, Georgians have access to a variety of resources to help them understand how to apply, shop, and enroll in coverage, including access to people who can help them right in their community.

Disability Income (DI) Insurance: What It Is and How It Works

What Is Disability Income (DI) Insurance?

The term disability income (DI) insurance refers to an insurance policy that provides income to individuals who can no longer work because of a disability. Disability income insurance helps protect people from financial losses if an accident or illness renders them incapable of working and receiving regular income.

DI insurance is available through employers, Social Security, or insurance companies and comes in short-term and long-term disability coverage. Premiums are based on a number of factors, including a person's age and occupation. Policies pay benefits on a monthly basis.

What Is Social Security?

Social Security is the Old-Age, Survivors, and Disability Insurance (OASDI) program in the United States. It's run by the Social Security Administration (SSA), a federal agency. It's best known for retirement benefits, but it also provides survivor benefits and income for workers who become disabled.

Over 72 million Americans will collect benefits from Social Security in 2024.

Key Takeaways

- Social Security is a federal program in the U.S. that provides retirement benefits and disability income to qualified individuals and their spouses, children, and survivors.
- Workers must be at least 62 years old and have paid into the system for 10 years or more to qualify for Social Security retirement benefits.
- Workers who wait to collect Social Security until age 70 will receive higher monthly benefits.
- The amount of retirement benefits is calculated based on your average indexed monthly earnings (AIME) during your 35 highest-earning years. It varies from person to person.
- People who can’t work due to a disability and surviving spouses and children may also be eligible for benefits if they meet certain requirements.

How Social Security Works

Social Security is an insurance program. Workers pay into the program, typically through payroll withholding from their paychecks. Self-employed workers pay Social Security taxes when they file their federal tax returns.

The Basics on Payroll Tax

What Is a Payroll Tax?

A payroll tax includes the taxes employees and employers pay on wages, tips, and salaries. For employees, taxes are withheld from their paychecks and paid to the government by the employer. These taxes include federal, state, and local income taxes. It also includes the employee's share of Social Security and Medicare taxes (FICA), which are paid to the federal government.

Taxes that employers must pay include their share of FICA as well as federal and state unemployment taxes. The employer's share of payroll taxes is paid directly by the employer and not withheld from employees' paychecks.

Key Takeaways

- Payroll taxes are withheld from every employee's salary and remitted to the federal government.
- In the U.S., payroll taxes are used to fund Social Security and Medicare.
- Both employers and employees have to pay an equivalent share of Social Security and Medicare taxes.

- Payroll taxes are used to pay for government spending, including Social Security, Medicare, local infrastructure, and other designated programs.

Understanding Payroll Taxes

Federal payroll taxes include Social Security and Medicare contributions, which constitute the Federal Insurance Contributions Act (FICA) tax in the United States. These are labeled as MedFICA and FICA on pay stubs. Federal income tax, which is also withheld from employee paychecks, goes into the general fund of the U.S. Treasury.

What Is the Social Security Tax?

The Social Security program, established in 1935, provides monthly financial benefits to workers when they reach retirement age, as well as to survivors of deceased workers (e.g., a spouse or child), and disabled workers.

The Social Security tax is the tax levied on employers and employees to fund the Social Security program in the U.S. The revenue is collected in the form of a payroll tax and a self-employment tax.

Key Takeaways

- Social Security taxes fund the retirement, disability, and survivorship benefits that millions of Americans receive each year from the Social Security Administration.
- The Social Security tax rate is 12.4% and is divided evenly between employers and employees, on a maximum wage base of $168,600 in 2024 ($160,200 in 2023).
- Self-employed individuals pay the employer and employee portions of Social Security tax, but only on 92.35% of net business earnings.
- Certain groups, including some nonresident aliens and members of religious groups with specific views, are exempt from paying the Social Security tax.

The Social Security Tax for Employees

The Social Security tax is mandated by the Federal Insurance Contributions Act (FICA).1 It pays for the benefits that Americans receive under the Old-Age, Survivors, and Disability Insurance (OASDI) program—the official name for Social Security.

The Social Security tax is applied to income earned by employees and self-employed taxpayers. Employers usually withhold this tax from employees' paychecks and forward it to the government.

The funds collected for Social Security are not put into a trust for the individual employee currently paying into the fund, but are rather used to pay existing older people in a "pay-as-you-go" system.2

The Social Security tax is also collected to support individuals who are entitled to survivorship benefits—benefits paid to a surviving spouse upon the death of their spouse or to a dependent child upon the death of their parent(s).2

As of 2024, the Social Security tax rate is 12.4%. Half of the tax, or 6.2%, is paid by the employer, and the other 6.2% is paid by the employee.

The Social Security tax rate is assessed on all types of income earned by an employee, including bonuses.3

However, there is an income limit above which the tax cannot be applied. The limit for 2024 is $168,600. For 2023, it's $160,200.4

The Social Security Tax for Self-Employed People

The self-employment tax (which, for self-employed people, includes the Social Security tax) is mandated by the Self-Employed Contributions Act (SECA).

It's applied to the net earnings of the self-employed, up to an income limit: $168,600 in 2024, and $160,200 in 2023. Since the Internal Revenue Service (IRS) considers a self-employed individual to be both an employer and an employee, they have to pay the full 12.4% Social Security tax on their own.

The self-employment tax is made up of the Social Security tax and the Medicare tax. As of 2024, the self-employment tax is 15.3% (12.4% Social Security tax + 2.9% Medicare tax).5 The tax is applied to 92.35% of net business earnings.

Example

Chen, who runs a human resources consulting business, calculates his total net income for 2024 to be $200,000 after business expenses have been deducted. His self-employment tax rate will be assessed at 92.35% of $200,000, or $184,700 (.9235 x $200,000).

However, since this amount is above the $168,600 income limit, his tax bill actually will be 15.3% of $168,600, or $25,795.80 (.153 x $168,600).

Chen can claim an above-the-line deduction for half of his self-employment tax, or $12,897.90 ($25,795.80 ÷ 2). In effect, he gets a partial refund on the 7.65% employer portion of his self-employment tax (6.2% Social Security + 1.45% Medicare).

The U.S. Social Security program provides Americans with some financial protection from earnings lost due to retirement, death, or disability. Retired workers, their families, and survivors of deceased workers receive monthly benefits payments. Social Security is funded mainly by the taxes that employees, their employers, and self-employed individuals pay throughout their working years.

Exemptions

Not every taxpayer has to pay the Social Security tax. Exemptions are available to specific groups of individuals, including:

- Members of a religious group who are opposed to receiving Social Security benefits during retirement, if disabled, or after death.
- Nonresident aliens—that is, individuals who are neither citizens nor legal residents of the United States, such as people who are in the country temporarily as students.
- Nonresident aliens working in the U.S. for a foreign government1.
- Students who are employed at the same school where they are enrolled, and where employment is contingent upon continued enrollment.

Example of Social Security Taxes

The Social Security tax is a regressive tax, meaning that a larger portion of lower-income earners' total income is withheld, compared with that of higher-income earners.12

Consider two employees, Aleksandr and Diego. Aleksandr earns $85,000 for the tax year 2024 and has the 6.2% Social Security tax withheld from his pay. The federal government collects $5,270 (.062 x $85,000) from Aleksandr to help pay for retirement, survivorship, and disability benefits.

Diego, on the other hand, earns $175,000 for the tax year 2024. The Social Security tax rate will only be applied up to the limit of $168,600.

Therefore, Diego will pay $10,453.20 (.062 x $168,600) as his contribution to the country's Social Security program for older people, survivors, and people with disabilities. But his effective Social Security tax rate is 6.0% ($10,453.20 ÷ $175,000). Diego, with a lower income, is taxed at the higher 6.2% rate ($5,270 ÷ $85,000).

What Is the Social Security Tax?

The Social Security tax is the revenue collected by the U.S. government to finance the Social Security program. The tax is automatically collected via employee payroll, and both employers and employees fund the program. Self-employed people pay it via the self-employment tax as both employees and employers along with Medicare. They pay it when they file their taxes.

What Is the Social Security Tax Income Limit?

In 2024, the income limit for Social Security tax is $168,600 (for 2023, it was $160,200). That means employees will not have to pay tax on any amount they earn above $168,600.4

How Can I Avoid Paying Taxes on Social Security?

If you earn in retirement between $25,000 and $34,000 and file as an individual, you may have to pay up to 50% in taxes on your Social Security benefits. If you earn more than $34,000, you may have to pay up to 85%. To minimize the tax, you can earn less, move income-generating assets into an individual retirement account (IRA), minimize withdrawals from retirement plans, or donate your required minimum distributions (RMDs).13

At What Age Is Social Security Not Taxable?

Social Security is always taxable, regardless of age. Your income in any given year determines whether or not your Social Security benefits are taxed.

The Bottom Line

The Social Security tax (at a rate of 12.4% as of 2024) is applied to the earned income of Americans throughout their working years. The revenue derived from the Social Security tax funds the Old-Age, Survivors, and Disability Insurance (OASDI) program, which is commonly known as Social Security.

Most states as well as some cities and counties, impose income taxes, which are also withheld as payroll taxes. In addition, employers, but not employees, also pay federal unemployment taxes for each of their employees.

Payroll taxes are collected by federal authorities and some state governments in many countries, including the U.S. These payroll tax deductions are itemized on an employee's pay stub. The itemized list notes how much is withheld for federal, state, and municipal income taxes, as well as the amounts collected for Medicare and Social Security payments.

Governments use revenues from payroll taxes to fund specific programs, including Social Security, healthcare, and workers' compensation. Local governments may collect a small payroll tax to maintain and improve local infrastructure and services, including first responders, road maintenance, and parks.

Payroll Tax Amounts

The premise of Social Security and Medicare is that you pay into them during your working years in order to qualify to withdraw these funds after retiring or under certain medical circumstances. An employee pays 7.65% of their pay for Medicare and Social Security (6.2% for Social Security and 1.45% for Medicare). An employer also pays the same tax of 7.65% for an employee, for a combined total of 15.3%.

Social Security Payroll Tax

Funds paid to Social Security taxes go into two trust funds: the Old-Age and Survivors Insurance (OASI) Trust Fund, which pays retirement and survivor benefits; and the Disability Insurance Trust Fund, for disability benefits. The Secretary of the Treasury, the Secretary of Labor, the Secretary of Health and Human Services, the Commissioner of Social Security, and two public trustees manage these trust funds.

The Social Security tax is 6.2%, paid by both the employee and the employer, for a total of 12.4%. In 2024, income above $168,600 in 2024 is not taxed for Social Security.

President Franklin D. Roosevelt signed the Social Security Act into law on Aug. 14, 1935, to provide a safety net for the disabled and retirees. When the program was conceived, high-wage earners were exempt from paying into the fund and receiving Social Security benefits; however, the U.S. Congress replaced the exemption with a cap that usually increases at the same rate as wages.

Medicare Payroll Tax

As noted above, payroll taxes also go toward Medicare. These payroll deductions go into one of two separate trust funds: the Hospital Insurance Trust Fund. The Hospital Insurance Trust Fund pays for Medicare Part A and the associated administration fees. Part A assists in covering hospital care, skilled nursing inpatient care, and, in some cases, home care.

Most people don't pay a premium for Part A (hospital insurance) since they likely paid into the program during their working years through the payroll tax. The tax for Medicare is 1.45% for the employer and 1.45% for the employee, for a total Medicare tax of 2.9%. For individuals that earn over $200,000, an additional 0.9% is charged. This additional tax only applies to the employee, not the employer.

The other Medicare trust fund is the Supplementary Medical Insurance Trust Fund, which assists in paying for Medicare Parts B and D and other Medicare program administration costs. Part B covers laboratory tests and screenings, outpatient care, x-rays, ambulance service, and many additional costs. Part D helps with prescription drugs. This trust fund is funded through the authorization of congress that allocates funds, the premiums from people who are enrolled in Part B and D, and other sources, such as interest earned on the fund's investments.

Unemployment Taxes

Employers bear the primary responsibility for funding unemployment insurance. If they lay off employees, those employees are entitled to unemployment benefits. The rate of unemployment insurance the employer will pay varies by industry, state, and federal fees. Some states also require employees to contribute to unemployment and disability insurance.

Self-Employment Taxes

Self-employed individuals, including contractors, freelance writers, musicians, and small business owners, must remit payroll taxes as well. These are sometimes referred to as self-employment taxes.

Unlike most salaried workers, self-employed people don't have employers to remit payroll taxes on their behalf. As a result, they must cover both the employer and employee portions of the tax on their own.

The self-employment tax rate for 2024 is 15.3%, including a 12.4% contribution to Social Security—old-age, survivors, and disability insurance. The other portion of the tax is a 2.9% payment to Medicare, with another 0.9% surtax for Medicare on earnings that exceed $200,000.

If you are self-employed, you can deduct the employer portion of FICA taxes as a business expense.

Payroll Taxes vs. Income Taxes

There is a distinction between a payroll tax and an income tax, although both are deducted from paychecks. Payroll taxes are used to fund specific programs. Income taxes go into the general funds at the U.S. Treasury.1 State income tax, if the state levies any, goes into the state's treasury.

Everyone pays a flat payroll tax rate up to a yearly cap. Income tax, however, are progressive. Rates vary based on an individual's earnings.

What Makes Up Payroll Taxes?

Payroll taxes include all of the taxes on an individual's salary, wage, bonus, commission, and tips. These taxes are used to pay for Social Security, Medicare, unemployment, government programs, and local infrastructure.

What Is the FICA Tax?

The FICA tax stands for Federal Insurance Contributions Act and is used to pay for Social Security and Medicare. The total tax is 15.3%, split evenly between an employer and an employee, meaning each pays a tax of 7.65%. This is made up of the Social Security tax (6.2%) and the Medicare tax (1.45%).

Does Everyone Pay a Payroll Tax?

Yes, for the most part, everyone pays a payroll tax, which is automatically deducted from one's paycheck. The Social Security and Medicare taxes are regressive (everyone pays the same amount), while income tax is progressive (those who make more are taxed at a higher rate). If you don't receive a paycheck, you must pay estimated taxes equivalent to what would have been withheld from your income.

The Bottom Line

Payroll taxes are the taxes employees and employers pay on wages, tips, and salaries. These taxes include federal, state, and local taxes, as well as FICA taxes, which are taxes for Social Security and Medicare. These taxes are all taken out of an employee's wages.

These taxes fund a range of programs, including Social Security, healthcare, defense spending, government salaries, and workers' compensation. Local governments may collect a small payroll tax to maintain and improve local infrastructure and services, including first responders, road maintenance, and parks.

Workers can earn up to four credits each year. One credit is granted up to $6,920 for every $1,730 earned in 2024, or up to four credits achieved.

The money goes into two Social Security trust funds: the Old-Age and Survivors Insurance (OASI) Trust Fund for retirees and the Disability Insurance (DI) Trust Fund for disability beneficiaries. These two funds are used to pay benefits to people who are currently eligible for them. The money that's not spent remains in the trust funds.6

A board of trustees oversees the financial operations of the two Social Security trust funds. Four of the six members are the secretaries of the Departments of Treasury, Labor, and Health and Human Services, and the Commissioner of Social Security. The remaining two members are public representatives appointed by the president and confirmed by the Senate.

Medicare is the federal health insurance program for Americans who are age 65 and older and some people who are receiving Medicare benefits due to disability. It's also supported through payroll withholding. This money goes into a third trust fund that's managed by the Centers for Medicare & Medicaid Services (CMS).

Social Security provides benefits to retirees, their survivors, and workers who become disabled.

Spouses and ex-spouses may be eligible for benefits based on the earnings records of their partners or former partners.

Who Can Get Retirement Benefits?

Workers who have paid into the Social Security system for at least 10 years become eligible for early retirement benefits at age 62.5 Waiting until your full retirement age (FRA) (between ages 66 and 67, depending on the year you were born) results in higher monthly benefits.12 You'll receive even more if you delay collecting retirement benefits until age 70, but benefits don't continue to increase if you wait any longer than that.

Spouses can also claim benefits based on either their own earnings records or their spouses' records. A divorced spouse who isn't currently married can receive benefits based on an ex-spouse's earnings record if the marriage lasted at least 10 years. Children of retirees can also receive benefits until they turn 18 or longer if the child is disabled or a student. The cutoff is age 16 if you're caring for a child who isn't your own.

How Much Can I Get in Social Security Benefits?

The amount of your Social Security retirement benefit depends on your average indexed monthly earnings (AIME) during your 35 highest-earning years. Amounts will differ significantly among retirees. The average monthly retirement benefit was $1,869.77 as of June 2024.

Your annual amount increases by 8% for each year that you delay collecting benefits if your retirement age is 66 to 67. This starts with the year after you reach your full retirement age and it stops at age 70. Those who begin taking Social Security when they reach the FRA of 66 would receive 100% of their primary insurance amount (PIA). They'd receive 108% of their PIA if they delayed taking benefits until the following year. They would receive 132% by delaying until age 70.

Social Security Administration. "Effect of Early or Delayed Retirement on Retirement Benefits."

The benefit varies depending upon when you begin taking it. The maximum monthly benefit for people aged 62 is $2,710 ($32,350 annually) in 2024. It's $4,873 ($58,476 annually) for those who have reached age 70.

A cost-of-living adjustment is made to Social Security benefits annually to keep pace with inflation. It was 8.7% for 2023 and it's 3.2% for 2024.

Workers can get a projection of their benefits at different retirement ages by using a calculator that's provided on the Social Security Administration website.

Social Security provides a special minimum benefit for long-term low earners that was first enacted in 1972. You must have income for at least 11 years to qualify. The special monthly minimum benefit was $50.90 ($610.80 annually) for December 2023. It increases for each additional year of low-income work, topping out at $1,066.50 or $12,798 annually for people who have worked for 30 years.

Who Can Get Disability Benefits?

People who can't work due to a physical or mental disability that's expected to last for a year or more or result in death may be eligible for Social Security disability benefits (SSDI). You generally have to meet certain earnings tests to qualify.20 Family members of disabled workers can also be eligible.

How Much Can I Get in Disability Benefits?

About 8.3 million Americans were collecting SSDI benefits as of June 2024. The average monthly benefit was $1,398.08 ($16,776.96 annually). The monthly average for disabled workers was $1,537.70 ($18,452.40 annually). Spouses of disabled workers received an average of $420.74 monthly ($5,048.88 annually) and children of disabled workers received $493.19 monthly ($5,918.28 annually).

Who Can Get Survivor Benefits?

The spouse and children of a deceased worker may be eligible for survivor benefits based on the worker's earnings record. This includes surviving spouses who are age 60 or older or age 50 or older and disabled. A surviving spouse who is caring for a child who is younger than 16 or disabled may be eligible for these benefits as well.

Children must generally be younger than 18 or disabled to receive benefits. A stepchild, a grandchild, a step-grandchild, or an adopted child may also qualify for benefits under certain circumstances.

Parents who are age 62 or older and who were dependent upon a deceased worker for at least half their income may also be eligible to collect benefits. Surviving spouses and minor children are also entitled to a one-time payment of $255 after an eligible worker's death under some circumstances.

How Much Can I Get in Survivor Benefits?

Approximately 5.8 million people were collecting survivor benefits as of June 2024. The average monthly benefit was $1,507.76 or $18,093.12 annually. Survivor benefits are broken down into five categories. Average payments in June 2024 were:

- Children of deceased workers: $1,105.32 monthly ($13,263.84 annually)
- Widowed mothers and fathers: $1,279.53 monthly ($15,354.36 annually)
- Nondisabled widow(er)s: $1,784.09 monthly ($21,409.08 annually)
- Disabled widow(er)s: $927.89 monthly ($11,134.68 annually)
- Parents of deceased workers: $1,618.45 monthly ($19,421.40 annually)1

The History of Social Security

The Social Security system was created on Aug. 14, 1935, when President Franklin D. Roosevelt signed the Social Security Act into law. The first monthly benefits checks became payable on Jan. 1, 1940. Ida M. Fuller, a retired legal secretary in Vermont, was the first person to collect one. Her check was for $22.54.

The system and its rules have evolved since 1935. Social Security is one of the largest government programs in the world, paying out hundreds of billions of dollars in benefits each year.

183 million

The number of people who paid Social Security taxes in 2023.

The Future of Social Security

Concerns have been raised about the aging of the U.S. population and the viability of a system in which fewer active workers will support a greater number of retirees as the cost of living continues to rise.

In its 2024 report, the Social Security Board of Trustees estimated that reserves in the retirement fund (OASI Trust Fund) will become depleted in 2033. This was unchanged from the previous year's projection. Ongoing tax revenue will be enough to pay only 79% of scheduled benefits after that time.

The report also projected that reserves of the Hospital Insurance (HI) Trust Fund that finances Medicare Part A will be depleted in 2036. This is five years later than projected in 2023. The program income will be able to cover 89% of scheduled benefits after 2036.

Congress will have to find ways to fill the gap if these predictions hold. This might mean higher taxes on workers, lower benefits, higher age requirements for retirees, or some combination of these elements.

What Benefits Does Social Security Provide?

Social Security provides monthly benefit payments for qualified retirees, disabled individuals, and for their spouses, children, and survivors. The benefit amount is based on several factors, including earnings history.

What Is the Difference Between Social Security and Supplemental Security Income (SSI)?

Supplemental Security Income (SSI) is a separate program from Social Security. It provides monthly cash distributions to elderly or disabled people with little to no income to help them meet their basic needs. You can be eligible for both Social Security benefits and SSI.

What Is Full Retirement Age (FRA)?

Full retirement age (FRA) is the age you must reach to be eligible to receive full retirement benefits from Social Security. Your FRA varies depending on when you were born. It's 66 years and two months for those born in 1955 and it gradually increases to age 67 for those born in 1960 or later.

The Bottom Line

The enactment of Social Security in 1935 was one of the signature achievements of President Franklin D. Roosevelt’s administration. The program remains a cornerstone of most Americans’ retirement, serving more than 72 million people.

Benefit amounts vary depending on income and years of employment. Surviving spouses, children, parents, and disabled workers and their family members may also be eligible to collect benefits in addition to retired workers.

The average retired worker's benefit amounts to about $20,000 annually so the program shouldn't be relied on as your sole source of retirement income. It's important to supplement it with other sources of retirement funding such as individual retirement accounts (IRAs), employer-sponsored plans such as a 401(k) or a 403(b), and other savings and investments.

Key Takeaways

- Disability income insurance provides insured individuals with income when they can no longer work because of an accident, injury, illness, and/or disability.
- DI insurance is available through employers, the Social Security Administration, or private insurance companies.
- Policies pay out benefits for short- or long-term disability coverage.
- Premiums are based on a number of factors, including a person's age and occupation.
- Policies pay benefits on a monthly basis, normally after the waiting period.

How Disability Income (DI) Insurance Works

Disabilities can cause a disruption in incomes and prevent people from maintaining their standards of living, paying their bills, or providing for their families. As many as 43% of individuals aged 40 will have a long-term disability by the time they turn 65. Enrolling in a disability income insurance policy can help individuals mitigate any losses that stem from an illness or accident that leads to a short- or long-term disability.

DI insurance isn't designed to guarantee 100% of your regular income. Instead, it intends to replace between 45% and 65% of your gross income. As noted above, most employers provide their employees with DI insurance benefits. This type of program is referred to as group insurance coverage. Benefits are also available to insured individuals and their families through the Social Security Administration (SSA). Individuals may choose to purchase DI insurance to supplement existing coverage or if they don't have any insurance at all.

Premiums are based on a series of factors, including your age and occupation. If you work in a field that has a higher risk of injury, your premiums will be higher. The amount of income you receive is also factored into how much you pay for coverage—the more you earn, the higher your premiums.1 Policies pay benefits in the event that illness, accident, or injury prevents you from performing the material and substantial duties of your occupation.

Benefits are tax-free because the policyholder uses after-tax dollars to pay premiums.

You may have to pay taxes on your benefits if your employer pays for your DI insurance coverage.

After-Tax Contribution: Definition, Rules, and Limits

What Is an After-Tax Contribution?

An after-tax contribution is money paid into a retirement or investment account after income taxes on those earnings have already been deducted. When opening a tax-advantaged retirement account, an individual may choose to defer the income taxes owed until after retiring, if it is a traditional retirement account, or pay the income taxes in the year in which the payment is made, if it is a Roth retirement account.

Some savers, mostly those with higher incomes, may contribute after-tax income to a traditional account in addition to the maximum allowable pre-tax amount. They don't get any immediate tax benefit. This commingling of pre-tax and post-tax money takes some careful accounting for tax purposes.

Key Takeaways

- There are pre-tax and after-tax contributions to retirement accounts.
- Traditional accounts consist of pre-tax contributions, and Roth accounts consist of after-tax contributions.1
- If you think you will have a lower income during retirement, a traditional account may make sense. If you think you will have a higher income during retirement, a Roth may make sense.
- The 2024 annual limit on funding an IRA is $7,000 per year if under 50 years of age ($8,000 for those age 50 or older). For 2023, those numbers were $6,500 and $7,500.
- The 2024 annual limit on funding a 401(k) is $23,000 per year if under 50 years of age ($30,500 for those age 50 or older). For 2023, those numbers were $22,500 and $30,000.

Understanding After-Tax Contributions

In order to encourage Americans to save toward their retirement years, the government offers several tax-advantaged retirement plans such as the 401(k) plan, offered by many companies to their employees, and the individual retirement account (IRA), which anyone with earned income can open through a bank or a brokerage.

Most, but not all, people who open a retirement account can choose either of the two main options:

- The traditional retirement account allows its owner to put pre-tax money in an investment account. That is, the money is not subject to income tax in the year it is paid in. The saver's gross taxable income for that year is reduced by the amount of the contribution. The IRS will get its due when the account holder withdraws the money, typically after retiring.
- The Roth account is the after-tax option. It allows the saver to pay in money after it is taxed. That is more of a hit to the person's immediate take-home income. But after retirement, no further taxes are owed on the entire balance in the account, as long as it's been five years since the first contribution was made to the account. There are Roth

IRAs, Roth 457(b)s, and Roth 403(b)s. The Roth 401(k) option (referred to as a designated Roth option) is newer, and not all companies offer them to their employees. Earners above a set limit are not eligible to contribute to a Roth IRA account.

Post-Tax or Pre-Tax?

The post-tax Roth option offers the attraction of a retirement nest egg that is not subject to further taxes. It makes the most sense for those who believe they may be paying a higher tax rate in the future, either because of their expected retirement income or because they think taxes will go up.

In addition, money contributed post-tax can be withdrawn at any time without penalty. (The same is not true for the profits in the account, however; account-holders must wait until they are 59½ to withdraw profits without penalty.)3

On the downside, the post-tax option means a smaller paycheck with every contribution into the account.

The pre-tax or traditional option reduces the saver's taxes owed for the year the contributions are made, and it is a smaller hit to current income. With a traditional account that is funded with pre-tax contributions, withdrawals are considered taxable income, whether it's money that was paid in or profits from the money earned.

Contribution Limits

Both post-tax and pre-tax retirement accounts have limits on how much can be contributed each year:

- The annual contribution limit for both Roth and traditional IRAs is $7,000 for tax year 2024 ($6,500 in 2023). Those age 50 or older can deposit an additional catch-up contribution of $1,000 in both 2023 and 2024.
- The annual contribution limit for both Roth and traditional 401(k) plans is $23,000 for tax year 2024 ($22,500 in 2023), plus up to an additional $7,500 for those age 50 and older in both 2023 and 2024.

If you have a pre-tax or traditional account, you will have to pay taxes on money withdrawn before age 59½. The funds are also subject to a 10% early withdrawal penalty.

Special Considerations

Withdrawals of after-tax contributions to a traditional IRA should not be taxed. However, the only way to make sure this doesn't happen is to file IRS Form 8606. Form 8606 must be filed for every year you make after-tax contributions to a traditional IRA and for every subsequent year until you have used up all of your after-tax balance.

Since the funds in the account are separated into taxable and non-taxable components, figuring the tax due on the required distributions is more complicated than if the account holder had made only pre-tax contributions.

What Are the IRA Limits?

The IRA contribution limits for 2023 are $7,000 ($6,500 in 2023). If you are age 50 or older, you may contribute an additional $1,000 in both 2023 and 2024. These limits are for both traditional IRAs and Roth IRAs.

Can I Contribute to Both a Traditional IRA and a Roth IRA?

Yes, you can contribute to both a traditional IRA and a Roth IRA. There are no restrictions on contributing to both; however, the total amount you contribute to both cannot be over the overall limit for IRAs set by the IRS. That limit in 2024 is $7,000. For 2023, it was $6,500. There's an additional $1,000 allowed in both years if you're 50 or older.

Is It Better to Do Pre-Tax or After-Tax Contributions?

Whether it's better to contribute on a pre-tax or after-tax basis will depend on your financial circumstances. The rule of thumb is that pre-tax contributions are better for higher-earners while after-tax contributions are better for lower-earners, particularly those who expect to be in a higher tax bracket when they retire.

The Bottom Line

After-tax contributions into retirement accounts can be beneficial if you expect to be in a higher income-tax bracket when you are retired. This may not always be the case, and everyone's situation is different. Generally, it's good to have a mix of retirement accounts that allow for tax advantages in the present and when you are retired.

Special Considerations

Disability income insurance policies contain a specific monthly benefit amount that is based on your monthly or annual income. For instance, your employer-provided benefit may pay $3,000 a month. Unless stated in the policy language, DI policies do not coordinate with Social Security benefits but pay in addition to it. Look for an indexed policy that keeps up to date with inflation, as your benefits likely won't kick in for some time.

Most insurance companies provide plans that carry a maximum benefit period of two, three, five, or 10 years. However, some companies have plans that pay up to the age of 65, 67, 70, or for the rest of your life. Once again, the price increases to purchase an extended benefit period.

Policies have waiting periods before you're able to receive any benefit payments. This refers to the amount of time or number of days that you are disabled before benefits kick in. These periods, which are also called elimination periods, vary by employer and insurer. The most common period is 90 days. The shorter the elimination period, the more expensive the premium.

Waiting Period: Definition, Types, and Examples

What Is a Waiting Period?

A waiting period is the amount of time an insured must wait before some or all of their coverage comes into effect. The insured may not receive benefits for claims filed during the waiting period. Waiting periods may also be known as elimination periods and qualifying periods.

Key Takeaways

- A waiting period, also known as a qualifying period, is the time before insurance coverage kicks in.
- Various insurance policies can have waiting periods, including homeowners insurance, auto insurance, and short-term disability.
- Waiting periods are often used by companies that experience high turnover rates.
- Some private health insurance plans have longer wait periods, such as for cancer or maternity care.

How a Waiting Period Works

The waiting period or elimination period before the insured may make claims varies by insurer, policy, and type of insurance. For more extended waiting periods before coverage is active, the cost of a premium may reduce slightly. In health insurance, there are several types of waiting periods.

An employer waiting period requires an employee to wait a specified period, such as three months, before they may receive company-subsidized health services. Often a provision like this will be in place for a company that expects a high turnover rate in employees. Once an employee enrolls, they may have an additional waiting period before they may claim on the coverage.

Health Maintenance Organizations (HMO) have affiliation waiting periods. The Health Insurance Portability and Accountability Act (HIPAA) regulates affiliation wait periods and does not allow them to exceed two months (three months for late enrollees).

A pre-existing condition exclusion period varies from one to 18 months. These wait times refer to specific health conditions an individual may have in the six months before enrolling in a health insurance plan. Coverage may be limited or excluded for the pre-existing condition. However, if the insured can prove uninterrupted insurance previous to changing policies, that coverage can count towards the pre-existing condition exclusion. Exemptions allow those who have at least one year of group health coverage at one job and a span of no more than 63 days to avoid this provision.

Some private health insurance plans come with long mandatory waiting periods for certain types of coverage:

- Cancer and cardiovascular care may have wait periods of up to two years.
- Maternity care waits may be as long as 10 to 12 months but commonly are 30 to 90 days.

- The dental care waiting period is typically 6 to 12 months. Some insurance companies also impose restrictions, or additional waiting periods, that control how often the insured may receive specific dental treatments. For example, denture replacement may be restricted to once every five years.

Policyholders need to consider their ability to pay for expenses when choosing the length of the waiting period for a policy.

Types of Waiting Periods

Homeowner insurance wait periods will usually span 30 to 90 days before coverage is in effect. After the waiting period expires, policyholders may file claims against the policy. Wait periods will vary by the insurance provider. Also, in some regions, such as coastal zones, when a named storm is in the area, new policies will not go into effect until after the storm passes.

Some states may impose wait periods on other insurance products. As an example, Texas will place a 60-day wait on new auto insurance policies. This period gives the provider a chance to decide if the driver fits within their risk profiles. During the 60-day period, the company may cancel the auto policy if they have concerns about the risk profile or undisclosed issues.

Short-term disability coverage can have wait periods as short as a few weeks, but these policies will have higher premiums. Most short-term policies wait 30 to 90 days for coverage. Long-term disability wait periods can be between 90-days and a full year. As with other insurance products, during the probationary period, no benefits are payable. For Social Security, disability payments will also have a waiting period of five months.

Policies do not pay 100% of an employee's salary and may not guarantee job protection. But there are certain protections that come with most policies. Noncancelable policies mean insurers can't cancel the policy for any reason unless you stop paying your premiums. Guaranteed renewable policies allow individuals to renew their policies without any changes. But the insurer may increase premiums at any time.

Not all disability income insurance policies are the same. You should review any coverage offered by your employer or private insurer before you sign up.

How to Get Disability Income Insurance

You aren't required to have DI insurance unlike other forms of coverage, such as homeowners insurance. But most employers provide their employees with some type of disability insurance as part of their annual benefits packages. They may also give the option of additional coverage. Premiums are paid through regular payroll deductions.

Workers' compensation is a form of disability insurance mandated by the government. Individuals receive benefits through employers who are covered by the Workplace Safety and Insurance Act. This form of disability insurance covers injuries or illnesses as a result of employment. Compensation usually covers medical fees that are related to an employee's injuries or the equivalent of sick pay during a medical leave.

The quality and scope of the employer-provided and workers' compensation coverage may leave a disabled employee short of the protection they require. Many employer-offered plans are part of a suite of coverage and may not pay to the levels an employee needs to meet their expenses. You can choose to elect supplementary coverage on your own through a private insurance company. This is especially important for self-employed individuals and small business owners who may not claim workers' compensation for themselves.

As noted above, you may qualify for disability benefits through the Social Security Administration. Social Security Disability Insurance and Supplemental Security Insurance (SSI) provide benefits to insured individuals and their families. Being insured means you worked long (and recently) enough and contributed through Social Security taxes on your earnings. This means you don't actually purchase coverage through the SSA the same way you would through a private insurance company. You must apply online, by phone, in person, or by mail to begin receiving benefits, which are capped. Changes are made each year by the agency.

California, Hawaii, New Jersey, New York, Rhode Island, and Puerto Rico require all employers to take part in disability income plans. Participation in any type of plan is completely voluntary for employers in other states.

Types of Disability Income (DI) Insurance

Disability income insurance comes in two different types: Short- and long-term disability coverage. We've noted some of the basic components of each below.

Short-Term Disability Income Insurance

Short-term disability provides employees with coverage for time spent away from work for a short period of time. Wage insurance covers events, such as an illness, accident, or injury, where the employee intends to return to work after a few weeks, months, or a year. Most STD policies have a waiting period of zero to 14 days before benefits kick in. Benefits may only be paid for a maximum of two years.

Long-Term Disability Income Insurance

As the name implies, long-term disability insurance covers individuals who may experience more lengthy or lifelong events. Employer plans normally work in conjunction with STD plans. This means that individuals begin receiving STD benefits before any long-term benefits kick in. Put simply, long-term benefits begin after any short-term benefits are fully paid out.

The waiting period for LTD benefits can range anywhere between a few weeks to several months. The maximum benefit goes beyond STD coverage, from a few years to the rest of the insured individual's life.

The Cost of Disability Income (DI) Insurance

The final premium for disability income insurance varies and is based on a number of factors. Policy premiums generally range between 1% and 3% of your gross income.10 Insurance underwriters also consider age during the underwriting process. The minimum age for applicants is 18 while the maximum tends to be 60. Unlike life insurance, DI insurance rates for women are higher per unit of coverage than those for male applicants.

Insurers have historically paid more and higher dollar amounts for claims filed by women. This includes those filed during an earlier period of their lives. This may be attributed to pregnancy, childbirth, and higher rates of depression and autoimmune disorders. Smokers can also expect to pay as much as 25% more for the same protection as non-smokers because of the higher incidence of smoking-related illnesses.

When determining premiums, providers often place applicants into career and income classifications. The basis of these classifications is on the carrier's claim experience for these job categories and incomes. The classification with the lowest risk pays less.

Business Overhead Expense Policy

- **Description**: Covers business expenses such as rent, utilities, and employee salaries if the business owner becomes disabled.
- **Example**: A policy that pays $5,000 per month to cover office rent and utilities while the owner is recovering from surgery.

What Is Disability Income Insurance?

Disability income insurance is a type of insurance policy that provides financial support to individuals who become unable to work due to a disability.

This coverage helps replace a portion of the policyholder's income, making it easier for them to maintain their financial stability and meet their expenses during their recovery period.

Disability income insurance is an essential component of financial planning because it helps protect individuals and their families from the potential financial hardships that may result from an unexpected illness or injury.

The loss of income during a disability can significantly impact a person's financial situation, making it difficult to cover essential expenses such as housing, medical care, and daily living costs.

Disability income insurance policies typically cover a wide range of disabilities, including both physical and mental health conditions that may prevent an individual from working.

Some examples include musculoskeletal disorders, cardiovascular diseases, mental health disorders, and neurological conditions.

Types of Disability Income Insurance

Short-Term Disability Insurance

Coverage Period

Short-term disability insurance provides coverage for a limited time, usually ranging from three to six months. This type of policy is designed to provide temporary financial support to individuals recovering from a brief illness or injury.

Benefit Amounts

Short-term disability insurance policies typically offer a benefit amount that replaces a percentage of the policyholder's pre-disability income, often around 60-80%. This amount is usually paid out on a weekly or monthly basis, depending on the policy terms.

Waiting Period

Short-term disability insurance policies typically have a waiting period, also known as an elimination period, which is the time between the onset of the disability and when the policyholder starts receiving benefits.

Waiting periods can range from a few days to a few weeks, depending on the policy.

Long-Term Disability Insurance

Coverage Period

Long-term disability insurance provides coverage for an extended period, which can last several years or until the policyholder reaches a specified age, such as 65.

This type of policy is designed to provide financial support to individuals who are unable to work due to a long-lasting or permanent disability.

Benefit Amounts

Long-term disability insurance policies generally offer a benefit amount that replaces a percentage of the policyholder's pre-disability income, similar to short-term disability insurance.

However, long-term policies typically have a lower percentage, ranging from 50-70%. The benefit amount is usually paid out on a monthly basis.

Waiting Period

Long-term disability insurance policies often have a longer waiting period compared to short-term policies. Waiting periods can range from 30 days to several months, depending on the policy.

Comparison of Short-Term and Long-Term Disability Insurance

Short-term and long-term disability insurance policies differ in terms of their coverage periods, benefit amounts, and waiting periods.

Short-term policies provide temporary financial support for brief periods of disability, while long-term policies offer extended coverage for longer-lasting or permanent disabilities.

Additionally, short-term policies typically have shorter waiting periods and higher benefit amounts compared to long-term policies.

Types of Disability Income Insurance

Key Features of Disability Income Insurance

Benefit Period

The benefit period refers to the length of time during which the policyholder receives disability income benefits. Depending on the policy, the benefit period can last from a few months to several years or until the policyholder reaches a specified age.

Elimination Period

The elimination period, also known as the waiting period, is the time between the onset of the disability and when the policyholder starts receiving benefits. Elimination periods can vary depending on the type of policy and the policyholder's preferences.

Definition of Disability

Disability income insurance policies use different definitions of disability to determine eligibility for benefits, which can significantly impact the scope of coverage. The two most common definitions of disability are:

Own-Occupation

Under the own-occupation definition, a policyholder is considered disabled if they are unable to perform the duties of their specific occupation due to an illness or injury.

This definition offers broader coverage, as it considers the policyholder disabled even if they can still work in a different job.

Any-Occupation

The any-occupation definition considers a policyholder disabled only if they are unable to work in any occupation for which they are reasonably suited based on their education, training, and experience. This definition offers narrower coverage and may result in fewer claims being approved.

Residual Benefits

Residual benefits are a feature of some disability income insurance policies that provide partial benefits to policyholders who experience a partial loss of income due to a disability. This feature helps support individuals as they transition back to work or adjust to a reduced work capacity.

Cost of Living Adjustments (COLA)

Cost of Living Adjustments (COLA) is an optional feature in some disability income insurance policies that increases the benefit amount to account for inflation over time. This ensures that the policyholder's benefits maintain their purchasing power throughout the benefit period.

Non-cancelable and Guaranteed Renewable

Non-cancelable and guaranteed renewable provisions ensure that the insurance company cannot cancel the policy or increase the premiums as long as the policyholder continues to pay their premiums on time. These features provide long-term stability and peace of mind for the policyholder.

Factors Affecting Disability Income Insurance Premiums

Several factors can influence the cost of disability income insurance premiums, including:

Age

Premiums typically increase with age, as older individuals have a higher likelihood of experiencing a disability.

Gender

Women often pay higher premiums than men, as they generally have a higher risk of experiencing a disability during their working years.

Occupation

High-risk occupations, such as construction or manual labor, can result in higher premiums due to the increased likelihood of work-related injuries and disabilities.

Health and Lifestyle

Individuals with pre-existing health conditions or risky lifestyle habits, such as smoking, may face higher premiums due to the increased likelihood of experiencing a disability.

Coverage and Benefit Options

The coverage and benefit options chosen by the policyholder, such as the elimination period, benefit period, and optional riders, can significantly impact the cost of premiums.

Understanding Group and Individual Disability Income Insurance

Group Disability Income Insurance

Pros and Cons

Group disability income insurance is a type of coverage that is commonly offered by employers as part of their employee benefits package. Some advantages of group coverage include lower premiums, simplified underwriting, and easy enrollment.

However, group coverage may offer limited customization options, and benefits may be taxable if the employer pays the premiums.

Commonly Offered by Employers

Many employers offer group disability income insurance to their employees as a way to attract and retain talent. Employees can often choose to enroll in the coverage during their annual benefits enrollment period.

Individual Disability Income Insurance

Pros and Cons

Individual disability income insurance policies are tailored to the specific needs and preferences of the policyholder. Advantages of individual coverage include customizable benefit options, portability, and non-taxable benefits (when premiums are paid with after-tax dollars).

However, individual policies may have higher premiums and require a more thorough underwriting process compared to group coverage.

Tailored to Individual Needs

Individual disability income insurance policies can be customized to suit the unique needs and preferences of the policyholder, including their preferred elimination period, benefit period, and optional riders.

Understanding Group and Individual Disability Income Insurance

How to Choose the Right Disability Income Insurance Policy

Assessing Your Needs and Financial Situation

Before choosing a disability income insurance policy, it's important to assess your financial situation and determine how much coverage you need.

Consider factors such as your current income, expenses, existing savings, and any other financial resources you have access to in case of a disability.

Comparing Policies and Providers

Once you have a clear understanding of your needs, compare different policies and insurance providers. Look for features that are important to you, such as the definition of disability, elimination period, benefit period, and optional riders.

Additionally, compare premium costs and the financial strength of the insurance companies.

Working With a Financial Advisor or Insurance Agent

A financial advisor or insurance agent can provide expert guidance and help you navigate the process of choosing the right disability income insurance policy. They can help you assess your needs, compare policies, and ensure you make an informed decision.

Periodically Reviewing Your Coverage

As your financial situation and needs change over time, it's important to periodically review your disability income insurance coverage to ensure it remains adequate. Consider updating your coverage if you experience significant life changes, such as a change in income, family status, or job.

Claims Process for Disability Income Insurance

Filing a Claim

If you become disabled and need to file a claim for disability income insurance benefits, you will need to follow your insurance provider's specific claims process. This typically involves submitting a claim form, along with any required documentation and medical records.

Providing Documentation and Medical Records

When filing a claim, you may need to provide documentation, such as proof of your income and employment status, as well as medical records and reports from your healthcare providers.

This information will be used by the insurance company to assess your claim and determine your eligibility for benefits.

Appeals Process for Denied Claims

If your claim is denied, you have the right to appeal the decision. The appeals process may involve submitting additional documentation or evidence to support your claim.

It's essential to follow your insurance provider's specific appeals process and timelines to ensure your appeal is properly considered.

Conclusion

In conclusion, disability income insurance is a critical component of a comprehensive financial plan, offering vital protection against the financial challenges that may arise due to an unexpected disability.

This type of insurance can help replace a portion of a person's income, enabling them and their families to maintain financial stability and cover essential expenses, such as housing, medical care, and daily living costs.

As the impact of a disability can be significant, it is crucial for individuals to carefully consider their insurance needs and options to ensure they have adequate coverage in place.

To find the most suitable disability income insurance policy, individuals should thoroughly research different policies and providers, comparing key features such as the definition of disability, elimination period, benefit period, and optional riders.

Additionally, working with a financial advisor or insurance agent can provide valuable guidance and expertise to help navigate the selection process. Periodic reviews of coverage are also essential, as financial situations and needs change over time, necessitating adjustments to insurance policies.

By taking these steps, individuals can better safeguard their financial well-being and have greater peace of mind in the face of potential disabilities.

Disability Income Insurance FAQs

What is disability income insurance?

Disability income insurance is a type of insurance policy that provides financial protection for individuals who are unable to work due to a disability or injury. It pays out a portion of your income to help you cover your living expenses while you are unable to work.

Who needs disability income insurance?

Anyone who relies on their income to cover their living expenses should consider disability income insurance. This includes people who are self-employed, freelance workers, and those who do not have access to disability benefits through their employer.

How much does disability income insurance cost?

The cost of disability income insurance varies depending on several factors, including your age, occupation, and health status. Generally, the younger and healthier you are, the lower your premiums will be. Premiums can range from a few hundred dollars to several thousand dollars per year.

What does disability income insurance cover?

Disability income insurance covers a portion of your income if you are unable to work due to a disability or injury. The amount of coverage you receive depends on the terms of your policy. Some policies may also provide additional benefits, such as coverage for medical expenses or rehabilitation.

How do I choose the right disability income insurance policy?

When choosing a disability income insurance policy, it's important to consider factors such as the amount of coverage you need, the length of the benefit period, and the waiting period before benefits begin. It's also a good idea to compare policies from multiple insurers to find the best coverage at a price you can afford. Working with an experienced insurance agent can also help you navigate the process and find the right policy for your needs.

Business Disability Buyout Policy

- **Description**: Provides funds to buy out a disabled partner's share of the business.
- **Example**: A policy that pays $500,000 to buy out a partner who can no longer work due to a severe accident.

Types of disability insurance

There are two main types of personal disability insurance — short term and long term. But there are other kinds of personal disability insurance policies, along with Social Security disability and state disability insurance.

All disability insurance replaces your income while you're hurt or sick and can't work, but there are different types of policies and coverage.

The ten main types of disability insurance are:

- Personal and group disability insurance
- Long-term disability insurance
- Short-term disability insurance
- Business overhead expense insurance
- Mortgage disability insurance

- Social Security disability insurance
- State disability insurance
- Supplemental disability insurance
- Workers' compensation

If you're not sure what kind of disability insurance to get, or you want to compare quotes to make sure you get the best rates for your coverage needs, talk with an agent.

Personal and group disability insurance

A policy that you buy for yourself is called **personal** or **individual** disability insurance (also called private disability insurance), while one you get through work as an employee benefit is called group disability insurance.

The main difference between group disability insurance and a personal policy is that a group policy is controlled by your employer and tied to your job, so you don't get to keep the coverage if you leave. Since you usually pay for group disability policies with pre-tax dollars, your benefits are taxable.

Group disability insurance is also more likely to be short-term coverage, so it may be a good idea to get a personal long-term policy even if you already have group disability coverage through your job.

Long-term disability insurance

Long-term disability insurance can last anywhere from one year to through retirement age (usually 65 to 67). The longer your benefit period, the more expensive your policy will be.

Most long-term disability policies cover up to 60% of your gross income (which should come close to what you take home after taxes) and cost between 1% to 3% of your salary. So if you make $120,000 a year, you might pay between $100 and $300 a month for a policy.

Long-term disability insurance is best for high earners or people with jobs that require a lot of schooling or specialized training who want to protect their incomes.

Types of long-term disability insurance

When you buy long-term disability insurance, you can choose between own-occupation and any occupation coverage:

- **Any-occupation**: Only pays benefits if you can't work *any job* that you're reasonably suited for. Any-occupation coverage is cheaper, but it's harder to qualify for benefits.
- Own-occupation: Pays out when you can't work the specific job that you're trained for (like a heart surgeon or a lawyer), even if you can work in another, related role.

Types of own-occupation disability insurance

There are also multiple types of own-occupation coverage.

- **True own-occupation**: You'll still get paid out even if you can still work, as long as you're unable to do the specific job you had before your illness or injury
- **Transitional own-occupation**: If you can't work in your specialized role due to injury or illness, but you can get a new lower-paying job, you can still get benefits. You can collect your entire benefit as long as your new salary and your benefits don't add up to more than what you used to make.
- **Own-occupation, not engaged**: You'll only get paid if you can't work in your original role and you haven't yet found a new job. Once you start a new job, no matter the field, you'll stop receiving benefits.

Short-term disability insurance

Like long-term disability insurance, short-term disability insurance covers up to 60% of your pre-tax income if you can't work. The difference is that short-term disability coverage usually only lasts for up to a year.

It's worth having short-term disability insurance if you get it for free or at a discount through your job but, since it can cost as much as long-term disability insurance, it might be a smarter investment to get long-term disability insurance instead.

Business overhead expense insurance

Business overhead expense insurance is a special kind of disability insurance for small business owners. It doesn't cover your personal expenses — that's what a personal disability insurance policy does. A business overhead policy pays for your business's overhead costs while you can't work, including:

- Accounting fees
- Employee salaries
- Payroll taxes
- Postage
- Rent
- Utilities

Mortgage disability insurance

Mortgage disability insurance, which is also sometimes called mortgage payment protection insurance, is a type of limited long-term disability insurance that covers your mortgage payments while you can't work due to an illness or injury.

You can buy mortgage disability insurance through your mortgage lender, an insurance agency, or a broker.

Mortgage disability insurance doesn't require the typical underwriting process or medical exam that other long-term disability insurance policies do, so it might be worth having if you don't qualify for regular long-term disability coverage but don't want to risk defaulting on your mortgage.

Credit disability insurance

Your bank or mortgage lender may offer you credit disability insurance on top of your loan, which is a type of coverage that can help make your mortgage payments if you're sick or injured and can't work.

But credit disability insurance offers less coverage than a regular disability insurance policy. It's also more expensive, and you may have to pay interest on your premiums, so if you can qualify for a regular long-term disability option, that's probably a better option.

Social Security disability insurance

Social Security disability insurance, or SSDI, is disability coverage that you get through the federal government. While SSDI is free, it's hard to qualify for coverage and the benefits are much lower than with other types of disability insurance.

To qualify for SSDI, you have to have a condition that's expected to keep you out of work for at least a year. You must also meet work and income requirements and go through a potentially long screening process in order to qualify.

→ Read more about Social Security disability insurance

State disability insurance

Some states offer temporary disability insurance plans, which are funded by deductions from your paychecks. Most of these plans offer coverage for up to a year.

The following states (and U.S. territory) have state disability insurance programs, also known as temporary disability insurance:

- California
- Hawaii
- New Jersey
- New York
- Rhode Island
- Puerto Rico

You can't purchase state insurance through an agent or broker, and benefits don't usually pay out for more than one year.

Supplemental disability insurance

A supplemental disability insurance policy adds more coverage to any disability insurance you already have. It's a great way to get more disability benefits or extend your benefit period without paying for an entirely new policy or going through another medical exam.

Supplemental disability insurance can close the gap between an employer-sponsored disability plan (which can be taxed or capped), and the full amount of money you'll need to cover your expenses in case you can't work.

Workers' compensation

Workers' compensation, also known as workers' comp, is a type of insurance that your employer is required to provide. While workers' compensation pays out if you become injured at work, it's different from disability insurance.

Workers' comp actually offers less coverage than disability insurance does, and you can only qualify if your injury happened at work. A regular disability insurance policy doesn't have this restriction — you can get benefits no matter where your injury happened.

Hurt on the job? A state-by-state guide to workers' compensation

Updated September 18, 2020: Workers' compensation covers income and medical care if you are injured or become ill as a direct result of your job. It does not cover illness or injury incurred off the clock or unrelated to your job duties. That's because workers' compensation is insurance for **employers**. Businesses purchase a policy from private insurers or special state funds. This policy provides medical and wage benefits if a worker files and the insurer approves a claim.

For personal protection, **employees** need disability insurance, which covers your income if you can't work due to illness or injury. (We can help you compare and buy disability insurance across carriers.)

How workers' compensation works

If you have been injured on the job, it's important to know your rights — especially because they vary widely, depending on where you live. Most workers' compensation laws are set by your state. It determines which businesses must carry coverage, how much and how long they must pay an injured or ill employee, and what penalties are imposed if a company doesn't comply with the laws.

States also sets time limits for every step of the workers' comp claim process. Employees must formally report a job-related illness or injury to their employer within a certain time period, usually 10 to 90 days. They also must file a claim with their state workers' compensation agency, though those deadlines are much broader.

Employers and insurers, meanwhile, have a certain amount of time, usually 14 to 30 days, to investigate, process and approve or deny claims. Most states allow you to appeal a denial. That appeal must also be filed and processed by the state-imposed deadlines.

The types of workers' compensation benefits

Workers' compensation generally requires employers — or, by extension, their insurer — cover all reasonable **medical expenses** associated with an injury or illness occurred on the job. Often, there are restrictions regarding which health care providers you can visit or paperwork involved when switching physicians.

Wage benefits generally fall into four buckets:

- **Temporary total disability benefits (TTD)** are paid out to employees while they're unable to work and recuperating from a workplace illness or injury. There's usually a waiting period (akin to the elimination period associated with disability insurance) for TTD, meaning the injury must keep you out of work for a certain number of days before you're eligible to file a claim. TTD typically continues until you return to work, reach maximum medical improvement or receive benefits for the maximum number of weeks allotted by the state.
- **Temporary partial disability benefits (TPD)** are paid out to employees who can return to work in a modified or "light duty" capacity. The amount is usually the difference of what you're paid under TTD and what you're making in the new position. They end when you return to work full-time or reach the maximum number of weeks alloted by state law.
- **Permanent partial disability benefits (PPD)** are paid out when an employee experiences a permanent impairment, like loss of a limb, as a result of a workplace incident. The payment correlates to the severity of the disability and is determined in a myriad of ways. Most commonly, a number of weeks is assigned to your injury and multiplied by the wages you're eligible for under TTD. PPD is generally determined and paid out after you reach maximum medical improvement. You are eligible for PPD even if you're receiving other workers' comp wage benefits.
- **Permanent total disability benefits (PTD)** are paid out to workers' who are severely disabled due to a job-related injury and cannot return to the workforce as a result. Some states cap PTD. Many reduce benefits once the employee qualifies for Social Security Disability Insurance.

Most states also stipulate employers pay death benefits and burial expenses to dependents of employees who died as a direct result of a workplace incident. Again, these benefits are no substitute for a private life insurance policy, which broadly covers the unexpected death of a loved one. (Learn how life insurance works.)

Remember, workers' compensation laws are complex. Your state's program administrator or an experienced attorney can walk your through the applicable nuances. Scroll down to see the basic workers' compensation laws in your state.

Workers' compensations laws by state

Alabama workers' compensation

Program administrator: Alabama Department of Labor, Workers' Compensation Division

Employers required to provide coverage: Any business with five or more full-time or part-time employees, excluding contractors.

Medical benefits: Employers are responsible for hospital, surgical and medical treatment during the period of disability.

Temporary total disability benefits: Equal to two-thirds of your average weekly wage, but subject to the state's maximum benefit allowance. As of July 1, 2018, the maximum

benefit is $865 per week. The minimum benefit is $238 per week. The number of weeks you are eligible for temporary total benefits is unlimited.

Temporary partial disability benefits: Equal to two-thirds of your average weekly wage, minus the compensation you're receiving for light duty or modified work. TPD is capped at 300 weeks. Total and partial disability benefits don't cover the first three days of lost wages unless you are out of work for 21 days or longer (you'll receive back pay).

Permanent partial disability benefits: Varies by illness or injury, but subject to a cap of $220 per week. Benefits are limited to 300 weeks.

Permanent total disability benefits: Equal to two-thirds of your average weekly wage, subject to the state maximum. The time you can receive benefits is unlimited.

Other notable coverage: Death benefits, equal to 50% or two-thirds of the employee's average weekly wage, are available to qualified dependents for up to 500 weeks. Employers are also responsible for up to $6,500 in funeral expenses for workers killed as a direct result of their job.

Alaska workers' compensation

Program administrator: Alaska Department of Labor and Workplace Development

Employers required to provide coverage: Any employer with one or more employees, unless they've been approved to self-insure.

Medical benefits: Employers must pay at least two years' worth of qualified medical expenses.

Temporary total disability benefits: Equal to 80% of your spendable weekly wages, subject to the state maximum, which amounts to no more than 120% of the state's average weekly wage. At a minimum, insurers must pay you at least 22% of the maximum weekly rate or, if you fail to provide proof of income, at least $110 per week. Benefits are paid every two weeks until you're medically stable or can return to work (whichever comes first).

Temporary partial disability benefits: Equal to 80% of the difference between your spendable weekly wage prior to the disability and your spendable weekly wage under light duty. TPD benefits pay out until you reach medical stability or up to five years (whichever comes first).

Permanent partial disability benefits: Paid in addition to TTD. Once you're medically stable, a doctor will determine how impaired you are and you'll be compensated based on a percentage of $177,000, depending on the severity of your injury. You'll receive payment in a lump sum.

Permanent total disability benefits: Equal to 80% of your spendable weekly wages, minus the amount of any permanent partial disability award you received and adjusted for inflation. PTD benefits last until the disability ends or death.

Other notable coverage: The program provides a $5,000 death benefit, $10,000 in funeral expenses and weekly income replacement equal to TTD benefits to surviving spouses and children.

Arizona workers' compensation

Program administrator: The Industrial Commission of Arizona

Employers required to provide coverage: Any business with one or more full-time or part-time employee, with a few standard exceptions. (Standard exceptions include sole proprietors who are eligible to self-insure or absent employees, independent contractors and people who employ domestic workers in their private home.)

Medical benefits: Employers are responsible for paying medical expenses directly related to the workplace illness or injury. These expenses include emergency room charges, doctor's fees, doctor visits and prescriptions.

Temporary total disability benefits: Equal to two-thirds of of your average monthly wage, subject to the state maximum. For 2019, the maximum monthly wage for the purposes of calculating benefits is $4,741.57 per week. Wages are not paid out on the first 7 consecutive lost days of work unless your disability lasts 14 days or more (then back pay is issued). Benefits are paid every two weeks until a doctor clears you for work.

Temporary partial disability benefits: Equal to two-thirds of of your average monthly wage minus your wages for light duty. TPD gets paid out once a month until you are cleared to resume full-time work.

Permanent partial disability benefits: Compensation for "scheduled" permanent injuries, such as loss of an arm, leg or eye, ranges from 50% to 55% of the average monthly wage. Workers who suffer facial scarring or teeth loss are eligible for benefits equal to 55% of the average monthly wage for up to 18 months. Compensation for "unscheduled" injuries, including occupational diseases and injuries to the hip, shoulder, or back, is 55% of the difference between your average monthly wage and the amount ICA estimates you can earn given your injury.

Permanent total disability benefits: Equal to 75% and two-thirds of the average monthly wage for scheduled injuries and unscheduled injuries, respectively. Benefits continue until your death, unless the ICA rules otherwise or you fail to file a mandated annual report of income. PTD is paid each month, unless you are awarded a special lump sum commutation.

Other notable coverage: Surviving spouses, minor children, parents and minor siblings are eligible for death benefits of up to 66.67% of the deceased worker's average monthly wage until death or remarriage. The program also offers a burial allowance of up to $5,000.

Arkansas workers' compensation

Program administrator: Arkansas Workers' Compensation Commission

Employers required to provide coverage: Businesses with three or more employees, with a few exceptions.

Medical benefits: Employer must cover all reasonably necessary medical care. However, they have the right to designate the initial provider and your claim can get denied if you seek non-emergency treatment without notice.

Temporary total disability benefits: Equal to two-thirds of your average weekly wage, subject to the state's maximum. For 2019, the TD maximum is $695. Payments are made every other week for as long as you are unable to work. Benefits are not paid out on the first seven days of disability, beginning the day after it occurs, unless you are out of work for 14 calendar days or more. In that case, back pay is issued.

Temporary partial disability benefits: Equal to two-thirds of your average weekly wage minus what you are making on light duty, subject to the state's maximum.

Permanent partial disability benefits: Varies by amount of wages and number of weeks, depending on the severity of your injury. The PPD rate for amputation or permanent total loss of use of a member is the same as your TD rate, subject to the state maximum. For 2019, the PPD maximum is $521 per week.

Permanent total disability benefits: Equal to two-thirds of your average weekly wage, subject to the state's weekly maximum. Arkansas also caps PTD benefits. As of 2019, maximum compensation equals $225,875.

Other notable coverage: Spouses, children and other dependents are eligible to receive weekly benefits in the event an employee's work-related death. The amount and length of payments vary, depending on their relationship to the deceased. The program pays up to $6,000 in funeral expenses.

California workers' compensation

Program administrator: California Department of Industrial Relations, Workers' Compensation Division

Employers required to provide coverage: Any business with one or more employee, excluding sole proprietors who do not have to self-insure. Temporary, part-time and even contractors may be entitled to workers' comp.

Medical benefits: Employers must pay for medical expenses "reasonably required to cure or relieve" the workplace disability. You are limited to 24 chiropractic visits, 24 physical therapy visits and 24 occupational therapy visits unless a claims administrator approves extended care. Employers can require you stay in their medical network for care.

Temporary total disability benefits: Usually equal to two-thirds of your wages prior to injury, subject to the state maximum. In 2019, if your gross wages were more than $1,877.07 per week before you were hurt, the maximum TTD payment is $1,151.38 per week. If your gross wages before the injury were less than $281.57 per week, the minimum TTD payments are $187.71 per week.

Temporary partial disability benefits: Equal to two-thirds of your wages prior to the injury, minus what you are making for light duty and subject to the state maximum. TD benefits are paid every two weeks. Benefits typically last until a doctor clears you to work or up to 104 weeks within five years from the date of injury. At that point, if you can no longer work, you might qualify for permanent disability benefits.

Permanent partial disability benefits: The length and amount of compensation varies by disability, date of injury and your wages before the disability. As an example, total

loss of vision in one eye (not adjusted for age or occupation) could warrant close to $35,000 in PPD.

Permanent total disability benefits: The amount of compensation varies by disability, date of injury and your wages before the disability, but if you are deemed permanently disabled due a workplace illness or injury, you could be entitled to benefits for life.

Other notable coverage: Injured employees can receive supplemental job displacement benefits, which are vouchers that help pay for vocational rehabilitation. Spouses, children and other dependents are eligible for up to $320,000 in death benefits, depending on the number of bereaved, as well up to $10,000 for funeral expenses. The death benefit is paid out at the total temporary disability rate, subject to a minimum of $224 per week.

Colorado workers' compensation

Program administrator: Colorado Department of Labor and Employment

Employers required to provide coverage: Companies with one or more full- or part-time employers, with limited exceptions

Medical benefits: Employers must cover all reasonable and necessary medical bills for workers disabled on the job. However, they can stipulate a network of health care providers. You can switch doctors once if you are within 90 days of the incident and have not medically improved.

Temporary total disability benefits: Equal to two-thirds of your average weekly wage as of the date of your injury, subject to a maximum of $987.84 in 2018. Benefits are not paid out if the disability causes you to miss work for three days or less. If you are out of work for longer than three days, you will receive back pay for that missed time.

Temporary partial disability benefits: Equal to two-thirds of your average weekly wage, up to a state maximum, as of the date of your injury, minus what wages you are making on a modified schedule.

Permanent partial disability benefits: Compensation varies by disability, date of injury and your wages before the disability. Scheduled impairments are payable at a weekly compensation rate of $307.26, while non-scheduled impairments are paid out at the TTD rate, subject to a $150 per week minimum and $542.78 per week maximum in 2018. Body disfigurement benefits are between $5,229.68 and $10,457.52.

Permanent total disability benefits: Equal to two-thirds of the average weekly wage in effect at the time of the injury or illness paid for the lifetime of the injured worker.

Other notable coverage: Dependents are eligible for a death benefit of between $246.96 and $987.84 per week and up to $7,000 for burial expenses. If a deceased worker has no dependents, the insurer pays out up to $20,836.09 to the Colorado Uninsured Employers Fund.

Connecticut workers’ compensation

Program administrator: State of Connecticut’s Workers’ Compensation Commission

Employers required to provide coverage: Companies with one or more full- or part-time employers, with the exception of those that can self-insure.

Medical benefits: The employer is responsible for covering all necessary and appropriate medical treatment. They can choose the health care provider of initial treatment, but the employee has the right to choose their attending physician.

Temporary total disability benefits: Equal to 75% of the after-tax-and-Social-Security average weekly wage the injured worker was making before the incident, subject to the state maximum of $1,298 per week. TTD and TPD aren't paid out until the worker is out for three calendar days. They are paid starting on the fourth day of missed work and compensated for the first three days if they are too injured or ill to work for seven days or longer. Employers must pay a weekly minimum equal to 20% of the maximum weekly benefit ($259.60) not to exceed 75% of the employee's average weekly wage.

Temporary partial disability benefits: Equal to 75% of the after-tax-and-Social-Security average weekly wage the injured worker was making before the incident minus the wages they are making on light or modified duty. TPD is subject to a state maximum of $1,046 per week.

Permanent partial disability benefits: The length and amount of compensation varies by injury. Benefits run between $50 and $1,046 and nine to 208 weeks.

Permanent total disability benefits: Equal to 75% of the injured worker's after-tax average weekly wage, subject to the state maximum of $1,298 per week. You can potentially receive benefits for the length of your life.

Other notable coverage: Surviving spouses or eligible dependents are entitled to a death benefit equal to 75% of the deceased worker's after-tax average weekly wage, subject to the maximum, plus $4,000 for burial expenses.

Delaware workers' compensation

Program administrator: Delaware Division of Industrial Affairs

Employers required to provide coverage: Employers with one or more employees, excluding contractors. Farmers are exempt from workers' comp laws.

Medical benefits: Employers are responsible for paying for all necessary medical treatment and hospitalization services.

Temporary total disability benefits: Equal to two-thirds of the injured employee's gross weekly wages received at the time of the injury, subject to the state maximum. As of 2018, the maximum was $713.65 per week. Minimum compensation was $237.88 per week. No benefits are paid out on the first three days of missed wages, unless the injury causes the worker to miss seven days or more. At that point, back pay is issued.

Temporary partial disability benefits: Equal to two-thirds of the injured employee's gross weekly wages prior to injury minus what they are making on a modified schedule, subject to the state maximum. TPD is available for up to 300 weeks.

Permanent partial disability benefits: Equal to two-thirds of the average week wage paid out for 20 to 220 weeks, depending on the severity of your permanent injury.

Permanent total disability benefits: Equal to two-thirds of the injured employee's gross weekly wages received at the time of the injury, subject to the state maximum. Benefits are potentially payable for life.

Other notable coverage: Spouses and dependents are eligible for weekly death benefits, but they cannot exceed 80% of the state maximum. Benefits are paid out for a maximum of 400 weeks, but cease after certain life events. Say, a spouse remarries or a minor child turns 18 (or 25, if in school). They also receive up to $3,500 in funeral expenses,

Florida workers' compensation

Program administrator: Florida Division of Workers' Compensation

Employers required to provide coverage: It varies by industry. Construction companies must provide workers' comp when they have one or more employee, including the owner if they're a corporate officer or LLC. Non-construction companies must carry insurance if they have four or more employees, subject to the same parameters. Agriculture companies have a slightly higher threshold at six or more employees. There are exemptions for owners who can self-insure.

Medical benefits: Employers are responsible for all necessary medical care, treatment and prescriptions related to your injury.

Temporary total disability benefits: Equal to two-thirds of your average weekly wage, calculated using wages earned 13 weeks prior to your injury, though some severe injuries may entitle you to 80% of your regular wages for up to six months. TTD, TPD or a combination of the two are paid out for no more than a maximum of 104 weeks. You aren't paid for the first seven days of lost wages unless you are out of work for over 21 days, in which case back pay might be issued.

Temporary partial disability benefits: Up to two-thirds of your average weekly wage, calculated using wages earned 13 weeks prior to your injury, minus the income you are making on a modified schedule.

Permanent partial disability benefits: The length and amount of compensation varies, depending on your illness or injury. Maximum compensation as of 2018 was $917 per specified week.

Permanent total disability benefits: Equal to two-thirds of the average weekly wage, paid out until the injured worker reaches 75 years of age, unless the employee is not eligible for Social Security due to their inability to work.

Other notable coverage: Surviving dependents are eligible for a total of $150,000 in compensation to cover funeral expenses (up to $7,500), income replacement and educational benefits in the case of a spouse.

Georgia workers' compensation

Program administrator: Georgia's State Board of Workers' Compensation

Employers required to provide coverage: Any business with three or more workers, including part-time employees.

Medical benefits: Employers are responsible for paying authorized doctor, hospital and rehabilitation bills for up to 400 weeks after your injury. They can request you visit select health care providers outside of initial emergency care, so long as you are provided with a choice of six doctors or more.

Temporary total disability benefits: Equal to two-thirds of your average weekly wage, subject to a maximum of $575 per week. TTD doesn't start until an employee has missed more than seven days of work. Those wages are only replaced if you injury or illness extends over 21 days. Benefits are paid out for a maximum of 400 weeks.

Temporary partial disability benefits: Equal to no more than $383 per week, paid out for up to 350 weeks.

Permanent partial disability benefits: Benefits vary by injury. As an example, if you lost an arm or leg you will receive benefits of 225 weeks.

Permanent total disability benefits: Equal to two-thirds of your average weekly wage, subject to a maximum of $575 per week, paid potentially for life.

Other notable coverage: Dependents are eligible to receive two-thirds of your average weekly wage as a death benefit, subject to a maximum of $575 per week. Surviving spouses are eligible for up to $230,000 in death benefits. However, payments cease if they remarry or cohabit with a new partner.

Hawaii workers' compensation

Program administrator: State of Hawaii Disability Compensation Commission

Employers required to provide coverage: Companies with one or more employees whether full-time, part-time, permanent or temporary workers with a few exceptions

Medical benefits: Employers are responsible for paying for treatment, hospital charges, prescription drugs, X-rays, physical therapy and reasonable transportation expenses related directly to the injury. Employees can choose their own physician.

Temporary total disability benefits: Equal to two-thirds of your average weekly wages, subject to the state maximum of $883 (as of 2018). There is a three-day waiting period for benefits. They last until you return to work or reach maximum medical recovery. At that point, you might be eligible for PPD or PTD.

Temporary partial disability benefits: Equal to two-thirds of your average weekly wages, subject to the state maximum minus the wages you make from your modified schedule.

Permanent partial disability benefits: The amount of compensation and length of benefits varies by injury.

Permanent total disability benefits: Equal to two-thirds of your average weekly wages, subject to the state maximum and potentially paid for life.

Other notable coverage: Hawaii also offers temporary disability insurance benefits to employees who lose wages to non-work-related illness or injury up to $620 per week. Surviving spouses and dependent minor children are eligible for death benefits equal to

TTD benefits, plus funeral expenses and burial expenses up to 10 times and five times the maximum weekly benefit rate, respectively.

Idaho workers' compensation

Program administrator: The Idaho Industrial Commission

Employers required to provide coverage: Companies with one or more full-time, part-time, seasonal or occasional employees with a few exceptions

Medical benefits: Employers are reasonable for covering “reasonable” medical care to treat workplace injuries.

Temporary total disability benefits: Equal to 67% of your average weekly wage, subject to the state maximum, which is 90% of its total average weekly wage. There’s a five-day waiting period. If your injury causes you to lose work for longer than two weeks, back pay is issued. TTD benefits are paid out for up to 52 weeks.

Temporary partial disability benefits: Equal to 67% of the decrease in your wages. TPD benefits cannot exceed TTD benefits.

Permanent partial disability benefits: Equal to (55%) of the average weekly state wage and paid out for one to 350 weeks, depending on the permanent disability.

Permanent total disability benefits: Equal to 67% of the average weekly state wage, subject to the state maximum and potentially paid for life.

Other notable coverage: Dependents are eligible for death benefits between 20% to 60% of the state average weekly wage, subject to the state maximum. Surviving spouses can receive benefits for up to 500 weeks with payments ceasing upon death or remarriage. Able-bodied minor children can receive benefits up until they turn 18 (or 23, if they are in school). Some compensation is provided for funeral expenses, if the death occurs within four years of the workplace injury.

Illinois workers' compensation

Program administrator: Illinois Workers’ Compensation Commission **Employers required to provide coverage:** Every employer located in Illinois.

Medical benefits: Employers are required to cover all medical care that is reasonably necessary to cure or relieve the employee from the injury. Employees can choose their health care provider with some restrictions.

Temporary total disability benefits: Equal to two-thirds of the employee’s average weekly wage, subject to the state maximum ($1,480.12 as of 2018). TTD is not paid out for the first three days of disability, unless the disability lasts two week or more. Benefits are paid until the employee returns to work or reaches maximum medical improvement.

Temporary partial disability benefits: Equal to two-thirds of the employee’s average weekly wage, subject to the state maximum, minus the *gross* wages the worker earns in their light-duty job.

Permanent partial disability benefits: Length and the amount of compensation varies, depending on the injury and whether the worker is able to secure a new job.

Permanent total disability benefits: Equal to two-thirds of your average weekly wages, subject to the state maximum and paid for life.

Other notable coverage: Death benefits, equal to two-thirds of the deceased's average weekly wages, are paid to surviving dependents for up to 25 years or $500,000, whichever is greater. They also receive up to $8,000 for funeral expenses.

Indiana workers' compensation

Program administrator: Workers' Compensation Board of Indiana

Employers required to provide coverage: Most businesses, with some exceptions, including train services.

Medical expenses: Employers must cover medical expenses related to the workplace injury. However, they can specify the health care provider.

Temporary total disability benefits: Equal to two-thirds of your average weekly wage, but not more than $780 per week as of 2018. You're not eligible for benefits until you miss more than seven days of work and you only receive back pay for those days if the disability lasts 21 days.

Temporary partial disability benefits: Equal to two-thirds of your average weekly wage prior to the injury minus your average weekly wages on light duty. TPD pays out for a maximum of 300 weeks.

Permanent partial disability benefits: Compensation varies, depending on the severity of your workplace injury. Indiana caps total compensation for TTD, TPD and PPD at $390,000 per person.

Permanent total disability benefits: Equal to two-thirds of the state's average weekly wage. Indiana caps PTD benefits at 500 weeks.

Other notable coverage: Dependents are eligible for death benefits equivalent to TTD benefits: Equal to two-thirds of the deceased average weekly wage, capped at 500 weeks. They also are eligible for up to $7,500 to cover funeral expenses.

Iowa workers' compensation

Program administrator: Iowa Division of Workers' Compensation

Employers required to provide coverage: Most businesses, excluding agriculture workers and contractors.

Medical expense: Employers must pay all reasonable and necessary medical care required to treat a workplace injury, including travel expenses for treatment.

Temporary total disability benefits: Generally equal to 80% of your spendable income, but varies by your average gross weekly earnings, number of income tax exemptions and marital status, but cannot exceed $1,765 per week. There's a three-day waiting period with back pay due for those days if you are out for longer than 14 calendar days. TTD benefits continue until you're healthy enough to return to work.

Temporary partial disability benefits: Equal to two-thirds of the difference between your average gross weekly earnings when injured and your actual earnings while working a modified schedule.

Permanent partial disability benefits: Compensation varies by severity of your injury. Weekly PPD is capped at $1,623 and 500 weeks.

Permanent total disability benefits: Equal to your TTD benefits, but paid out until death.

Other notable coverage: Surviving dependents are eligible for death benefits, potentially equal to the deceased TTD benefits. The employer must also pay for reasonable burial expenses not to exceed 12 times the statewide average weekly wage at the time of death.

Kansas workers' compensation

Program administrator: Kansas Department of Labor

Employers required to provide coverage: All employers outside of those in certain agricultural pursuits or with a gross annual payroll of $20,000 or less.

Medical benefits: Employers must cover all medical treatment reasonably needed to cure or relieve the effects of the injury. They can choose your health care provider. If you seek health care out of network, the insurer only has to pay $500 toward bills.

Temporary total disability benefits: Equal to two-thirds of your gross average weekly wage, subject to a weekly maximum of $645 and a total maximum of $130,000. There is a one-week waiting period before you're eligible for benefits.

Temporary partial disability benefits: Equal to two-thirds of the difference between your average gross weekly wage before the injury and your wages after the injury, subject to the $130,000 maximum.

Permanent partial disability benefits: Compensation varies based on the disability remaining after recovery and is capped at 415 weeks.

Permanent total disability benefits: Equal to two-thirds of your gross average weekly wage, subject to a weekly maximum of $645 and a total maximum of $155,000.

Other notable coverage: Surviving dependents are eligible for death benefits up to $300,000 in total compensation (at least $430 per week) and $5,000 for funeral expenses.

Kentucky workers' compensation

Program administrator: Kentucky Department of Workers' Claims

Employers required to provide coverage: Employers with one or more employees

Medical benefits: All reasonable medical care related to the injury

Temporary total disability benefits: Equal to two-thirds of your average weekly salary, subject to the state maximum ($933.25 as of August 2018). You're not eligible for benefits until you've missed eight calendar days of work, due to the disability. If you are out for longer than 15 days, back pay is issued.

Temporary partial disability benefits: N/A

Permanent partial disability benefits: Compensation varies by impairment and determined once you reach maximum medical improvement.

Permanent total disability benefits: * Equal to two-thirds of your average weekly salary, payable until you're eligible for Social Security.

Other notable coverage: Dependents are collectively eligible for death benefits up to 75% of the deceased average weekly wage, subject to the state maximum, with the exact amount varied by relationship and number of dependent children. If the worker died within four years of the injury, they can also receive a lump-sum settlement to pay for burial expenses and more. As of 2018, that lump-sum maximum is $83,336.22.

Louisiana workers' compensation

Program administrator: Louisiana Workforce Commission

Employers required to provide coverage: All companies with employees, including full-time, part-time, seasonal or minor workers and some subcontractors or independent contractors.

Medical benefits: Employers must cover all approved medical treatment and reasonable travel expenses to receive treatment. Employees can pick their own doctor.

Temporary total disability benefits: Equal to two-thirds of the employee's average weekly wage, subject to the state maximum of $655 per week in 2019. No compensation is paid for the first week, unless the disability continues for two weeks or longer, then back pay is issued. Benefits are paid out for the duration of the disability.

Temporary partial disability benefits: Equal to two-thirds of the difference between your pre-injury average monthly wages and the average monthly wage in your modified job, subject to the state maximum. Payable for up to 520 weeks.

Permanent partial disability benefits: You are eligible for a one-time payment of $50,000 if your workplace injury is deemed catastrophic.

Permanent total disability benefits: * Equal to two-thirds of the employee's average weekly wage, subject to the state maximum of $655 per week in 2019 and paid out potentially for life.

Other notable coverage: Surviving dependents are eligible for death benefits equal to the TTD benefits. If there are no other dependents, surviving parents are entitled to a one-time benefit of $75,000 each. The employer must also pay up to $8,500 in funeral expenses.

Maine workers' compensation

Program administrator: Maine Workers' Compensation Board

Employers required to provide coverage: Businesses with one or more employees, excluding sole proprietors, partners, LLC members and certain farming employers.

Medical benefits: Employers are required to cover reasonable medical care. They can stipulate your doctor. However, you can request a different health care provider after 10 days of treatment.

Temporary total disability benefits: Equal to two-thirds of your average weekly wage, subject to a weekly maximum of $829.30 as of 2018. There's a seven-day waiting

period for benefits. Back pay for those days are issued only if your disability causes you to miss 14 days or more. Payments are made as long as the disability lasts.

Temporary partial disability benefits: Equal to two-thirds of the difference between your average weekly wage before the injury and your average weekly wages after it. Payments are made for up to 520 weeks.

Permanent partial disability benefits: Compensation varies based on the severity of your injury. Benefits are considered payable for between 11 and 269 weeks.

Permanent total disability benefits: Equal to two-thirds of your average weekly wage, subject to a weekly maximum of $829.30 as of 2018, potentially paid out for life.

Other notable coverage: Surviving dependents are eligible for death benefits equal to two-thirds of the deceased's average weekly wage, payable for up to 500 weeks. They are also eligible for up to $4,000 in burial expenses and up to $3,000 as incidental compensation. Benefits for surviving spouses cease if the spouse dies or remarries. Benefits for minor children cease at age 18, unless the child is otherwise physically or mentally incapacitated.

Maryland workers' compensation

Program administrator: Maryland Workers' Compensation Commission

Employers required to provide coverage: Companies with one or more employees with exceptions made for sole proprietors, farming employers and independent contractors.

Medical benefits: Employers are required to cover reasonable medical care; employees can choose their health care provider.

Temporary total disability benefits: Equal to two-thirds of your average weekly wage not to exceed 100% of the state average weekly wage ($1,094 as of 2018). Employees are not compensated for the first three days of lost wages unless the disability lasts over 14 days. TTD continues until you return to work or reach maximum medical improvement.

Temporary partial disability benefits: Equal to 50% of the difference between your average weekly wage and the wage you're earning after your injury, capped at 50% of the State Average Weekly Wage ($547.00 as of 2018).

Permanent partial disability benefits: Compensation varies by severity of the injury, but cannot exceed $365 per week. Benefits are awarded for up to 250 weeks.

Permanent total disability benefits: Equal to your average weekly wage not to exceed 100% of the state average weekly wage ($1,094 as of 2018) to continue indefinitely.

Other notable coverage: Surviving dependents are eligible for death benefits equal to two-thirds the deceased's average weekly wage, subject to the state maximum, and up to $7,000 in funeral expenses. Benefits are paid out potentially until the dead worker would have turned 70 with standard exceptions (a spouse remarries; a child turns 18). Non-spouse or child dependents can receive a maximum death benefit of $73,690.

Massachusetts workers' compensation

Program administrator: Massachusetts Department of Industrial Accidents

Employers required to provide coverage: Almost all employers must carry workers' comp insurance, with sole proprietors, partners, LLC members, some cab drivers and seamen subject to exemptions.

Medical benefits: Employers must cover any reasonable and necessary medical treatment related to a job-related injury or illness, including mileage reimbursement.

Temporary total disability benefits: Equal to 60% of your gross average weekly wage, subject to the state maximum ($1,383.41 as of 2018) and paid out for up to 156 weeks. There's a five-day waiting period for benefits to kick in and you're only compensated for those five days if your disability lasts 21 days or more.

Temporary partial disability benefits: Equal to 75% of what your TTD benefits would be, payable for up to 260 weeks.

Permanent partial disability benefits: Benefits are dispersed in varying amounts, depending on the severity of your disability. Disfigurement compensation may not exceed $15,000.

Permanent total disability benefits: Equal to two-thirds of your gross wages, paid weekly for the duration of the disability.

Other notable coverage: Surviving spouses are eligible for up to $4,000 in funeral expenses and death benefits equal to two-thirds of the deceased worker's average weekly wage, subject to the state maximum. Minor children are also eligible for the death benefits. Surviving spouses can be paid until they die or remarry.

Michigan workers' compensation

Program administrator: Michigan Workers' Compensation Agency

Employers required to provide coverage: Companies regularly employing one or more employees for at least 35 hours per week for 13 weeks or longer in any 52-week period or all companies with three or more employees.

Medical benefits: Employers must cover all reasonable and necessary medical care for work-related injuries or diseases. They can choose the health care provider for the first 28 days of your treatment.

Temporary total disability benefits: Equal to 80% of your after-tax average weekly wage, subject to a state maximum ($900 per week as of 2018), paid for the duration of your disability. You don't qualify for benefits until you are out for seven days and back pay for those days is only issued if the disability lasts two weeks or more.

Temporary partial disability benefits: Equal to 80% the difference between your weekly wage before the injury and your weekly wage after the injury.

Permanent partial disability benefits: Any worker that suffers a loss is eligible for 65 weeks of compensation benefits regardless of whether their disability causes them to miss work. Beyond that, compensation varies on the severity of the loss.

Permanent total disability benefits: Equal to 80% of your after-tax average weekly wage, subject to a state maximum ($900 per week as of 2018), paid for the duration of your disability. Benefits reduce by 5% each year between the ages of 65 and 75.

Other notable coverage: Dependents are eligible for death benefits equal to 80% of the worker's after-tax weekly wage and up to $6,000 for funeral expenses.

Minnesota workers' compensation

Program administrator: Minnesota Department of Labor and Industry

Employers required to provide coverage: All employers with some exceptions, including some sole proprietors, corporation officers and LLC managers.

Medical benefits: Your employer must cover all reasonable medical care associated with your workplace illness or injury.

Temporary total disability benefits: Equal to two-thirds of your gross weekly wage at the time of injury, subject to the state maximum ($1,098.54 as of 2018). There's a three-day waiting period for benefits with back pay issued if the disability last longer than 10 days. TTD caps at 130 weeks.

Temporary partial disability benefits: Equal to two-thirds of the difference between what the you earned at the time of the injury and your earnings in your modified position. TPD is capped at 225 weeks paid out within 450 weeks after the date of your injury.

Permanent partial disability benefits: The amount varies by injury; PPD is generally paid out when TTD ends and when you reach maximum medical improvement.

Permanent total disability benefits: Equal to two-thirds of your gross weekly wage at the time of injury, subject to the state maximum. Once the insurer has paid $25,000 in PTD, it can reduce benefits by the amount you're receiving in Social Security Disability Insurance (SSDI) benefits.

Other notable coverage: Dependents are eligible for death benefits, but the amount and duration varies by their relationship to the deceased. Surviving spouses, for example, are eligible for 50% of the deceased's weekly wage at the time of the injury for up to 10 years, subject to state maximums. They can also receive up to $15,000 for burial expenses.

Mississippi workers' compensation

Program administrator: Mississippi Workers' Compensation Commission

Employers required to provide coverage: Companies with five or more employees; domestic and farm employers are exempt from having to carry coverage.

Medical benefits: Employers must cover all reasonable and necessary medical care for work-related injuries or diseases, including mileage reimbursement.

Temporary total disability benefits: Equal to two-thirds of the workers' average weekly wage, subject to the state maximum ($487.04 as of 2018). There's a five-day waiting period for benefits with back pay issued if the disability extends 14 days or more.

Temporary partial disability benefits: Equal to two-thirds of the difference between the workers' average weekly wage before and after the injury, subject to the state maximums.

Permanent partial disability benefits: Two-thirds of the workers' average weekly wage, subject to the state maximum for up to 200 weeks depending on the injury.

Permanent total disability benefits: * Two-thirds of the workers' average weekly wage, subject to the state maximum ($487.04 as of 2018). All benefits are capped at 450 weeks with a lifetime pay out of $219,168 as of 2018.

Other notable coverage: Surviving spouses and other eligible dependents receive death benefits equal to a certain percentage of the workers' average weekly wage for up to 450 weeks. Spouses also receive up to $5,000 for funeral expenses and an immediate $1,000 in compensation.

Missouri workers' compensation

Program administrator: Missouri Division of Workers' Compensation

Employers required to provide coverage: Companies with five or more employees, whether full-time, part-time or seasonal; construction companies must carry coverage if they have one or more employees.

Medical benefits: The employer is responsible for covering all medical treatment related to the injury, though it can choose the health care provider.

Temporary total disability benefits: Equal to two-thirds of your average weekly wage, subject to the state maximum ($947.64 per week through June 2019). There's a three-day waiting period for which back pay is issued if you are out of work for 14 days or longer.

Temporary partial disability benefits: Equal to two-thirds of the difference between your average earnings prior to the accident and the amount you are able to earn after the accident, subject to the state maximum ($947.64 per week through June 2019)

Permanent partial disability benefits: Compensation is equal to two-thirds of your average weekly wage, subject to the maximum ($496.38 per week), but paid out for varying number of weeks (as a lump sum) depending on the severity of your injury.

Permanent total disability benefits: Equal to two-thirds of your average weekly at the time of the injury, not to exceed the state maximum, but payable for the course of your life.

Other notable coverage: Surviving spouses and dependent children are eligible for weekly death benefits equal to two-thirds of the deceased's average weekly wage for the year prior to the accident (subject to the state maximum of $947.64 per week, and up to $5,000 in funeral expenses. Spouses are eligible for life until they remarry. Children are eligible until they turn 18 (22 if a full-time student).

Montana workers' compensation

Program administrator: Montana Department of Labor & Industry

Employers required to provide coverage: All businesses with employees

Medical benefits: Employers must cover reasonable doctor, hospital, prescription and medical care costs related to the injury. However, medical benefits cease 60 months from the date of the injury.

Temporary total disability benefits: Equal to two-thirds your gross wages, subject to the state maximum of $793 per week. Benefits begin 32 hours or four days after wage loss, whichever is less. You will receive back pay if the disability lasts 21 days or more.

Temporary partial disability benefits: Equal to the the difference between your average weekly wage at the time of injury, subject to a maximum of 40 hours a week, and the wages you earn in the modified schedule. Earnings cannot exceed your temporary total disability rate of $793 per week and is capped at 26 weeks, but the insurer can extend that period.

Permanent partial disability benefits: Compensation varies based on your injury, but is capped at $396.50 per week and a total of 400 weeks.

Permanent total disability benefits: Equal to TTD benefits, paid out until you are eligible for Social Security retirement benefits.

Other notable coverage: Surviving dependents are eligible for death benefits up to two-thirds of the deceased’s gross wages, not to exceed the state maximum weekly wage, and burial expenses up to $4,000. Surviving spouses are eligible for up to 500 weeks of benefits. Payments cease upon remarriage or death.

Nebraska workers' compensation

Program administrator: Nebraska State Employees Workers' Compensation

Employers required to provide coverage: All businesses with one or more employees

Medical benefits: Employers must cover reasonable, necessary medical care and prescriptions directly related to the work injury. You can choose your physician so long as you’ve seen them prior to the injury.

Temporary total disability benefits: Equal to two-thirds of your average weekly wage for 26 weeks prior to the injury, subject to a maximum of $831 per week. There’s a seven-day waiting period for benefits with back pay only issued if the disability lasts over 42 days. TTD benefits stop when you return to work or reach maximum medical improvement.

Temporary partial disability benefits: Equal to two-thirds of the difference between your average weekly wage and your weekly wage in the modified position. TPD is paid out for up to 300 weeks.

Permanent partial disability benefits: Paid at a rate of two-thirds of your average weekly wage times the number of weeks associated with the severity of your injury.

Permanent total disability benefits: Equal to two-thirds of your average weekly wage for 26 weeks prior to the injury, subject to a maximum of $831 per week, but payable for life.

Other notable coverage: Surviving spouses are eligible for weekly death benefits equal to two-thirds of the deceased's average weekly wage or 75% of their average weekly wage if they have children, subject to the state maximums. Benefits are payable for life or until the spouses remarries. They also receive up to $6,000 in burial expenses.

Nevada workers' compensation

Program administrator: Nevada Division of Industrial Relations

Employers required to provide coverage: Any company with one or more employees

Medical benefits: Employers must cover all medical expenses related to the workplace injury. However, they can choose your doctor(s).

Temporary total disability benefits: Equal to two-thirds your average weekly wage, subject to the state maximum ($897.82 per week for 2019). Benefits aren't paid out unless the disability causes you to miss five consecutive days or five cumulative days in a 20-day period. In that case, back pay is issued. TTD is paid out until you return to work or reach maximum medical improvement.

Temporary partial disability benefits: Equal to two-thirds your average weekly wage, subject to the state maximum, minus what you are making in your modified position. TPD benefits are capped at 24 months.

Permanent partial disability benefits: Benefits are paid out in varying amounts, depending on the severity of your disability and your age and wage.

Permanent total disability benefits: Equal to two-thirds your average monthly wage, subject to the state maximum ($897.82 per week for 2019). Benefits are paid out for life, but could be reduced by 10% if you receive a PPD payout.

Other notable coverage: Dependents are eligible for death benefits up to two-thirds of the deceased's salary and up to $10,000 in burial expenses.

New Hampshire workers' compensation

Program administrator: New Hampshire's Workers' Compensation Division

Employers required to provide coverage: All employers with any employees, full- or part-time

Medical benefits: The employer must cover the cost of all medical, hospital and remedial care related to the workplace injury.

Temporary total disability benefits: Equal to 60% the employee's gross average weekly wage, subject to the state maximum ($1,582.50 as of 2018). There's a three-day waiting period. Benefits are paid out on those three days if the disability lasts 14 days or more. They last until the employee returns to work or reaches maximum medical improvement.

Temporary partial disability benefits: Equal to 60% of the difference between prior injury earnings and post-injury earnings, subject to the state maximum.TPD paid out for up to 262 weeks.

Permanent partial disability benefits: Equal to your average weekly wage, multiplied by a number of weeks correlating to the severity of your injury. Weeks are capped at 350.

Permanent total disability benefits: Equal to 60% the employee's gross average weekly wage, subject to the state maximum ($1,507.50 as of 2016), paid out for the duration of your disability.

Other notable coverage: Surviving spouses and minor children are eligible for death benefits of up to 60% the employee's gross average weekly wage, subject to the state maximum ($1,582.50 as of 2018). and burial expenses up to $10,000.

New Jersey workers' compensation

Program administrator: New Jersey Division of Workers' Compensation

Employers required to provide coverage: All businesses, outside of state and federal government employers

Medical benefits: Employers are required to cover all necessary and reasonable medical treatment, prescriptions and hospitalization services. They can designate the treating physician.

Temporary total disability benefits: Equal to 70% your average weekly wage, not to exceed 75% of the state's average weekly wage (amounts to a maximum benefit of $921 in 2019). Benefits are paid out for a maximum of 450 weeks. At that point, you become eligible for PTD.

Temporary partial disability benefits: Technically, not applicable; However, New Jersey has a Temporary Disability Income (TDI) program for anyone too ill or injured to work. These workers can receive weekly benefits, up to the state maximum ($637 per week as of 2018) and for 26 weeks, even if the illness or injury didn't occur in the workplace.

Permanent partial disability benefits: Equal to 70% your average weekly wage, multiplied by a number of weeks correlated to the severity of your injury.

Permanent total disability benefits: Equal to 70% your average weekly wage, not to exceed 75% of the state's average weekly wage ($921 in 2019). Benefits are initially paid out for 450 week, after which the recipient must demonstrate they are still unable to work.

Other notable coverage: Dependents are eligible for death benefits up 70% of the deceased's average weekly, capped at the maximum ($921) and up to $3,500 in burial expenses.

New Mexico workers' compensation

Program administrator: New Mexico Workers' Compensation Administration

Employers required to provide coverage: Businesses with three or more workers, including part-time and temporary workers. Agricultural employers are exempt, however; and all construction businesses must carry coverage.

Medical benefits: Employers must cover reasonable and necessary medical care related to the work-related injury or illness indefinitely.

Temporary total disability benefits: Equal to two-thirds your average weekly wage, based on wages for the 26 weeks prior to the accident, subject to the state maximum ($814.64 per week). There's a seven-day waiting period for benefits and back pay is only issued for those days if the disability lasts for four weeks or longer.

Temporary partial disability benefits: Equal to two-thirds the difference between the regular and wages in the modified job, subject to the state maximum.

Permanent partial disability benefits: Compensation varies. Benefits are capped at 500 to 700 weeks, depending on the severity of the injury. They're paid once an injured workers reaches maximum medical improvement.

Permanent total disability benefits: Equal to two-thirds your average weekly wage, based on wages for the 26 weeks prior to the accident, subject to the state maximum, but paid out for the workers' lifetime.

Other notable coverage: Surviving dependents are eligible for death benefits equal to the deceased's TTD benefits, subject to the state maximum and capped at 700 weeks. They also receive up to $7,500.

New York workers' compensation

Program administrator: New York State's Workers' Compensation Board

Employers required to provide coverage: All businesses with employees, including day laborers, leased employees, borrowed employees, part-time employees, unpaid volunteers (including family members) and most subcontractors.

Medical benefits: Employers are required to cover all necessary medical care related to the illness or injury for the duration of your disability. Employees must use authorized providers, however, even for emergency care.

Temporary total disability benefits: Equal to two-thirds of your average weekly wage multiplied by the percentage of your disability, subject to the state maximum ($904.74 as of 2018). There's a seven-day waiting period for benefits. That first week is only paid out if your disability lasts longer than 14 days.

Temporary partial disability benefits: Equal to two-thirds of the difference between your wages prior and post injury, subject to the state maximum.

Permanent partial disability benefits: Compensation is equal to two-thirds your average weekly wage, subject to the state maximum, and multiplied by a number of weeks (up to 525 weeks) dictated by the severity of your injury.

Permanent total disability benefits: Equal to two-thirds of your average weekly wage multiplied by the percentage of your disability, subject to the state maximum, but paid out until death.

Other notable coverage: Surviving spouses and minor children are eligible for weekly death benefits equal to two-thirds of the deceased worker's average weekly wage for the year before the accident, subject to the state's maximum, and up to $12,500 in

funeral expenses. Surviving parents or the worker’s estate might be entitled to a $50,000 lump-sum death benefit.

North Carolina workers' compensation

Program administrator: North Carolina Industrial Commission

Employers required to provide coverage: All businesses with three or more employees with a few notable exceptions in the agriculture industry.

Medical benefits: Employers are responsible for covering medical care related to the injury, but can specify health care providers.

Temporary total disability benefits: Equal to two-thirds of your average weekly wage, subject to the state maximum ($1,028 as of 2019). There’s a 7-day waiting period for benefits with pay for those days only getting issued if your disability last 21 days or more. You are eligible for benefits until you return to work.

Temporary partial disability benefits: Equal to two-thirds of your average weekly wage prior to the injury minus the wages you are making on a modified schedule. Benefits are payable for up to 500 weeks.

Permanent partial disability benefits: Compensation varies by injury, but is limited to 300 weeks of pay.

Permanent total disability benefits: Equal to two-thirds of your average weekly wage, subject to the state maximum (==), paid for life.

Other notable coverage: Surviving dependents are eligible for death benefits equal to two-thirds of the deceased average weekly wage, subject to the state maximum, and up to $10,000 in burial expenses.

North Dakota workers' compensation

Program administrator: North Dakota Workforce Safety and Insurance

Employers required to provide coverage: All employers with employees including full-time, part-time, seasonal and occasional workers.

Medical expenses: The insurer must cover all reasonable medical care related to the workplace injury.

Temporary total disability benefits: Equal to two-thirds of your pre-injury gross weekly wage, plus $15 per week for each dependent child, subject to the state maximum. There’s a five-day waiting period for benefits.

Temporary partial disability benefits: * Equal to two-thirds of your pre-injury gross weekly wage minus your post-injury gross wages. TPD ends when your wages return to at least 90% of your gross weekly pre-injury wages and is capped at five years.

Permanent partial disability benefits: Amount varies by injury and is paid out once you reach maximum medical improvement.

Permanent total disability benefits: Equal to two-thirds of your pre-injury gross weekly wage, reduced by 50% once you’re receiving SSDI.

Other notable coverage: Varies by relationship to the deceased. Surviving spouses receive death benefits equal to two-thirds of a deceased's weekly wage, up to 125% of the state's average weekly wage, plus up to $15 each week for each dependent child. They also receive a one-time payment of $2,500, plus $800 for each dependent child, and up to $10,000 in funeral expenses. Total death benefits are capped at $300,000.

Ohio workers' compensation

Program administrator: Ohio Bureau of Workers' Compensation

Employers required to provide coverage: All employers with one or more employees

Medical benefits: Employers must cover all authorized medical treatment related to the injury, including mileage reimbursement.

Temporary total disability benefits: For the first 12 weeks of injury, benefits are equal to 72% of the worker's full weekly wage. After that, benefits are equal to two-thirds of your average weekly wage, subject to the current state maximum of $932 per week. There's a seven-day waiting period for benefits; they last for the duration of your disability.

Temporary partial disability benefits: Known as Wage Loss (WL) benefits in Ohio, you are eligible for benefits based on the reduction in your earnings, subject to the $932 max. Working wage loss benefits, comparable to standard TTD, caps at 200 weeks. Non-working wage loss, where you're actively seeking, but haven't found suitable employment, caps at 52 weeks. If you combine the two, benefits cap at 226 weeks with a few exceptions.

Permanent partial disability benefits: Awards are calculated by multiplying two-thirds of your average weekly wage by the number of weeks correlated to the severity of your injury. The maximum number of weeks is 200.

Permanent total disability benefits: Equal to two-thirds of the average weekly wage, subject to the current max, and payable for life.

Other notable coverage: Surviving dependents are eligible for death benefits based on level of dependency and subject to the $932 max, plus funeral expenses up to $5,500. Ohio also has a Disabled Workers' Relief Fund, which offers additional benefits to disabled workers whose income falls below the current cost of living.

Oklahoma workers' compensation

Program administrator: Oklahoma Workers' Compensation Commission

Employers required to provide coverage: Most businesses, with notable exceptions made for certain agricultural employers

Medical benefits: Employers must cover reasonable and necessary medical treatment related to the injury, though they can decide the health care provider.

Temporary total disability benefits: Equal to 70% of your average weekly wage, but can't exceed 70% of the state average weekly wage, and subject to the current state maximum of $590.63 per week (as of 2018). There's a three-day waiting period for

benefits. TTD can last for a maximum of 104 weeks, plus 52 weeks for any consequential injury.

Temporary partial disability benefits: Equal to 70% of the difference between the your pre-injury average weekly wage and your post-injury weekly wage, subject to the weekly cap of $320. Benefits are capped at 52 weeks.

Permanent partial disability benefits: Equal to 70% of the injured employee's average weekly wage (subject to a $323 max) multiplied by a number of weeks (up to 500) based on the severity of the injury.

Permanent total disability benefits: Equal to 70% of your average weekly wage, but capped at 100% of the state's average weekly wage, subject to the state max of $843.75 per week (as of 2018). PTD is available for 15 years or until you're eligible for maximum Social Security benefits (whichever comes first).

Other notable coverage: Surviving dependents are eligible for a lump sum death benefit based on their relationship to the deceased. A surviving spouse could receive s $100,000, plus 70% of deceased's average weekly wage or the state's average weekly wage, (subject to state maximums) whichever is the lesser amount. Death benefits also include up to $10,000 in funeral expenses.

Oregon workers' compensation

Program administrator: Oregon's Workers' Compensation Division

Employers required to provide coverage: Employers with one or more employees with few exceptions

Medical benefits: Employers will provide medical treatment, prescription drugs and most transportation, meals and lodging related to the on-the-job injury.

Temporary total disability benefits: Equal to two-thirds of your average weekly wage, subject to the state maximum of $1,339.38 per week through 2019. There's a three-day waiting period for benefits with back pay issued if you're out for 14 days in a row or hospitalized overnight within 14 days of the injury. TTD lasts indefinitely.

Temporary partial disability benefits: Equal to two-thirds of your average weekly wage before your injury minus your average weekly wage post-injury, paid for the duration of your disability.

Permanent partial disability benefits: Varies by date, severity of the injury, age of the worker, education and adaptability to perform a job post-disability. If amount awarded is greater than $6,000, it's paid monthly at 4.35 times the TTD rate or in a lump sum. If the award is under $6,000, it will be paid in a lump sum.

Permanent total disability benefits: Equal to two-thirds of the worker's average weekly wage, but subject to the state maximums. PTD could last for life. However, claims are re-evaluated every two years.

Other notable coverage: Death benefits are available to dependents, but the amount varies by their relationship to the deceased. Spouses are eligible for monthly benefits equal to 4.35 times two-thirds of the state's average weekly wage, which currently amounts to $2,920.59, plus funeral expenses up to $20,141.

Pennsylvania workers' compensation

Program administrator: Pennsylvania Department of Labor and Industry

Employers required to provide coverage: Employers with one or more employees, whether part-time or full-time, including family members.

Medical benefits: All reasonable medical care related to the injury

Temporary total disability benefits: Equal to two-thirds your gross weekly wage, subject to the state maximum ($1,025 as of 2018) with a few exceptions for low-paid employees. Capped at 104 weeks.

Temporary partial disability benefits: Equal to two-thirds of the difference between the your wages before and after the injury, capped at 500 weeks.

Permanent partial disability benefits: Equal to two-thirds your pre-injury wage, multiplied by a number of weeks, based on the loss in question.

Permanent total disability benefits: Equal to two-thirds your gross weekly wage, subject to the state maximum, with a few exceptions for low-paid employees. Once 104 weeks of TTD is paid out, you must have a medical exam to continue benefits.

Other notable coverage: Dependents are eligible for death benefits up to two-thirds of the deceased worker’s average weekly wage (subject to the state maximum), though the exact amount varies by relationship and the number of dependent children. Families are also eligible for up to $3,000 for burial expenses.

Rhode Island workers' compensation

Program administrator: Rhode Island Department of Labor and Training

Employers required to provide coverage: Employers with one or more employees, with standard exceptions

Medical benefits: The employer’s insurance covers all bills related to the injury, and you can pick your first primary physician. There are limits on palliative care once you reach maximum medical improvement.

Temporary total disability benefits: Equal to 75% of your spendable wage (earnings minus withholding) and subject to the state maximum ($1,253 as of 2018) and a three-day waiting period (no retroactive pay). You also receive $15 per dependent per week.

Temporary partial disability benefits: Equal to 75% of your spendable base wage (earnings minus withholding) minus what you are making in your modified position. TTD and TPD are available until you return to work or reach maximum medical improvement.

Permanent partial disability benefits: Depends on the severity of the injury, but benefits are generally between $45 and $90 per week for a certain number of weeks, paid with TTD or as a lump sum.

Permanent total disability benefits: Equal to 75% of your spendable base wage (earnings minus withholding) and subject to the state maximum.

Other notable coverage: Surviving spouses are eligible for benefits equal to 75% of the deceased's spendable base wages, subject to the state maximum, plus $40 per week per child and up to $20,000 in burial expenses.

South Carolina workers' compensation

Program administrator: South Carolina Workers' Compensation Commission

Employers required to provide coverage: Employers with four or more employers, including part-time workers and family members.

Medical benefits: Insurance covers 100% of medical expenses related to the workplace injury, but employers can select your treating physician.

Temporary total disability benefits: Equal to two-thirds of your average weekly wages, subject to a $838.21 maximum (as of 2018) and a seven-day waiting period, with back pay only issued if you're out of work for 15 days or more.

Temporary partial disability benefits: Equal to two-thirds of your average weekly wages minus what you're making, subject to 340-week cap.

Permanent partial disability benefits: The amount varies by severity of injury, but is subject to a 340 week-cap.

Permanent total disability benefits: Equal to two-thirds of your average weekly wages, but subject to a 500-week cap. Paraplegics, quadriplegics and employees who incur physical brain damage are eligible to receive weekly compensation benefits for life.

Other notable coverage: Dependents are eligible for death benefits up to 500 weeks and burial expenses up to $2,500.

South Dakota workers' compensation

Program administrator: South Dakota Department of Labor and Regulation

Employers required to provide coverage: None

Medical benefits: Employers must cover all medical bills related to the workplace injury. You can choose your doctor, but the employer and insurer are entitled to request a second opinion for which they must cover the cost.

Temporary total disability benefits: Equal to two-thirds of your average weekly wage, subject to a weekly $805 maximum and a seven-day waiting period. Benefits are paid until you return to work or reach maximum medical improvement.

Temporary partial disability benefits: Equal to two-thirds of your average weekly wage, minus your pre-injury wage.

Permanent partial disability benefits: Varies by disability, with payments made weekly or bi-weekly until a lump sum is approved.

Permanent total disability benefits: Equal to two-thirds of your average weekly wage, subject to the weekly maximum and payable for life.

Other notable coverage: Varies, depending on your relationship to the deceased. Surviving spouses are eligible for death benefits up to two-thirds of the deceased's

average weekly wage, subject to the state maximum, plus $50 per month per dependent child They can also receive up to $10,000 in burial expenses.

Tennessee workers' compensation

Program administrator: The Tennessee Department of Labor & Workforce

Employers required to provide coverage: Any employer with five or more employees, both full and part-time. There are some notable exceptions for construction and mining employers.

Medical benefits: The employer must cover all medical bills related to the employee's injury with some say over the treating physician, and travel expenses to and from medical treatment.

Temporary total disability benefits: Equal to two-thirds of your average weekly wages, subject to a $1,021.90 weekly maximum through June 2019 and an eight-day waiting period with back pay issued if the disability lasts 14 days.

Temporary partial disability benefits: Equal to two-thirds of the difference between your gross light duty wages and your average weekly wage.

Permanent partial disability benefits: Equal to two-thirds of your average weekly wages with the exact amount determined by the severity of the injury.

Permanent total disability benefits: Equal to two-third of your average weekly wages, subject to $929 weekly maximum through June 2019.

Other notable coverage: Equal to two-thirds of the deceased's average weekly wages, subject to the state maximum, when there is a surviving spouse and dependent; Equal to 50% of the deceased average weekly wages when there is only a surviving spouse. Dependents can also receive up to $10,000 for burial expenses.

Texas workers' compensation

Program administrator: Texas Department of Insurance

Employers required to provide coverage: None

Medical benefits: All reasonable medical care related to the injury

Texas structures benefits a bit differently. Employees are eligible for the following:

Temporary income benefits (TIB): Equal to 70% of the difference between your average weekly wage and the wages you earn after your work-related injury, subject to the state maximum ($938 as of 2018). TIB begins eight days after the injury and continues until you reach maximum medical improvement.

Impairment income benefits (IIB): If you reach maximum medical improvement, but are unable to return to work, you are eligible for IIB. Benefits are equal to 70% of your average weekly wage, subject to the state maximum ($656 as of 2018), payable for a number of weeks that correlates to the severity of your injury.

Supplemental income benefits (SIB): Severely disabled workers are eligible for SIB, once IIB payments run out. Benefits are equal to 80% of the difference between 80% of your average weekly wage and your weekly wages after your work-related injury,

subject to the state maximum ($656). TIB, IIB and SIB combined are capped at 401 weeks.

Lifetime Income Benefits (LIB): Equal to up to 75% of average weekly wages, initially subject to the state maximum ($938), with a 3% increase each year.

Other notable coverage: Surviving dependents are eligible for death benefits up to 75% of the deceased's average weekly wage, subject to state maximum ($938), and possible burial expenses.

Utah workers' compensation

Program administrator: Utah Labor Commission

Employers required to provide coverage: All employers with a few standard exceptions.

Medical benefits: The employer must cover all reasonable medical expenses related to the workplace injury. They can only stipulate a health care provider on your first visit.

Temporary total disability benefits: Equal to two-thirds of your average weekly wage, plus $20 for a dependent spouse and $20 per dependent child (up to four children), not to exceed 100% of the state’s average weekly wage ($879 through June 2019).

Temporary partial disability benefits: Equal to two-thirds the the difference between your average weekly wages before the accident and your weekly wages earned after the accident, plus your dependent allowance, but subject to the state maximums. TTD and TPD are capped at 312 weeks.

Permanent partial disability benefits: Equal to two-thirds of your average weekly, plus dependent allowance, multiplied by a number of weeks correlated to the severity of your injury.

Permanent total disability benefits: Equal to two-thirds of your average weekly wage for the first 312 weeks of disability. After which, compensation is 36% of the current state average weekly wage, rounded to the nearest dollar.

Other notable coverage: Surviving spouses are eligible for death benefits equal to two-thirds of the deceased’s average weekly wage, plus the dependent allowance, so long as it doesn’t exceed the state maximum, for a period of 312 weeks. After 312 weeks, extended benefits are subject to review. Dependents can also receive up to $9,000 in burial expenses.

Vermont workers' compensation

Program administrator: Vermont Department of Labor

Employers required to provide coverage: Employers with one or more full-time or part-time employees

Medical benefits: Employers must cover all reasonable medical care related to the injury.

Temporary total disability benefits: Equal to two-thirds of your standard wage, plus an extra $10 per week for each dependent child, subject to a weekly maximum of

$1,311 through June 2019. Benefits are subject to a four-day waiting period. They continue until you return to work or reach maximum medical improvement.

Temporary partial disability benefits: Equal to two-thirds of your standard wage minus your part-time pay.

Permanent partial disability benefits: Amount varies by severity of your injury and is paid periodically unless a request for a lump sum is approved by the state's Workers' Compensation and Safety Division.

Permanent total disability benefits: Equal to two-thirds of your standard wage, paid for a minimum of 330 weeks.

Other notable coverage: Death benefits vary by relationship to the deceased: Surviving spouses are eligible for two-thirds the average weekly wage, subject to the state's max, while surviving spouses with dependents are eligible for up to 76.6% of the deceased's average weekly wage. Dependents can also receive up to $10,000 in burial expenses.

Virginia workers' compensation

Program administrator: Virginia Workers' Compensation Commission

Employers required to provide coverage: Any business with more than two employees. Policies must cover all work performed in Virginia, even temporary work.

Medical benefits: All reasonable medical care related to the injury

Temporary total disability benefits: Equal to two-thirds your regular wages, based upon earnings for the 52 weeks prior to your injury, subject to the state maximum ($1,082 as of 2018). There's a seven-day waiting period for benefits, with back pay issued, if you're out of work for over 21 days. TTD is capped at 500 weeks.

Temporary partial disability benefits: Equal to two-thirds of the difference between the worker's wages before and after his injury, also capped at 500 weeks.

Permanent partial disability Benefits: Equal to two-thirds your regular wages, multiplied by a number of weeks correlated to the severity of your injury and paid out once you reach maximum medical improvement.

Permanent total disability benefits: Equal to two-thirds of your gross average weekly wage for the duration of the disability.

Other benefits: Dependents are eligible for death benefits up to two-thirds of the deceased average weekly wages, subject to the state maximum, for a maximum 500 weeks from the date of injury. They can also receive up to $10,000 in burial expenses.

Washington workers' compensation

Program administrator: Washington State Department of Labor and Industries

Employers required to provide coverage: Employers with one or more employees with the standard exceptions.

Medical benefits: Employers must cover all reasonable medical treatment related to your workplace injury. You may choose a doctor for your first visit, but after that, your employer can ask you stay in-network.

Temporary total disability benefits: Equal to 60% to 75% of your wages, depending on how many dependents you have and the state's current average weekly wage ($1,190 as of 2018) . There's a three-day waiting period for benefits; they're paid until you return to work or reach maximum medical improvement.

Temporary partial disability benefits: Equal to 80% of your pre-injury wages minus post-injury wages.

Permanent partial disability benefits: Varies, depending on the severity of your injury, which must be rated by a qualified doctor.

Permanent total disability benefits: Permanent and totally disabled workers are eligible for a monthly pension. The amount depends on your wages, the state's average wage at the time of your injury, your marital status, number of dependent children, health-care benefits and Social Security benefits.

Other notable coverage: Survivors are also eligible to receive this monthly pension; the maximum benefit is currently 120% of the statewide average wage for the year prior to the pension award. Domestic partners and spouses are also eligible for a one-time immediate death benefit and burial expenses.

Washington D.C. workers' compensation

Program administrator: Washington D.C. Department of Employment Services

Employers required to provide coverage: Employers with one or more employees

Medical benefits: Employers must cover all reasonable medical expenses related treatment for the workplace injury.

Temporary total disability benefits: Equal to two-thirds of your average weekly wage, subject to the state maximum ($1,491.90 as of 2018). Benefits are subject to a three-day waiting period (with back pay issued if the disability lasts longer than 14 days). They're paid until you return to work or reach maximum medical improvement.

Temporary partial disability benefits: Equal to two-thirds of your average weekly wage pre-injury, minus your average weekly wage post-injury, paid for a maximum of 5 years.

Permanent partial disability benefits: Equal to two-thirds of your average weekly wage multiplied by a number of weeks correlated to your injury.

Permanent total disability benefits: Equal to two-thirds of your average weekly wage, subject to the state maximum and potentially available for life.

Other notable coverage: Death benefits vary by relationship to the deceased, with surviving spouses or domestic partners eligible to receive benefits totaling 50% of the average wages of the deceased, subject to the state maximum, and an additional 16.6% of the wages per dependent child. They're also eligible for up to $5,000 in funeral expenses.

West Virginia workers' compensation

Program administrator: West Virginia

Employers required to provide coverage: All employers with a few standard exceptions

Medical benefits: All reasonable medical care related to the injury

Temporary total disability benefits: Equal to two-thirds of your average weekly wage, subject to a state maximum of $823.14 as of 2018 and limited to 104 weeks.

Temporary partial disability benefits: Equal to 70% of the difference between your average weekly earnings before and after the injury, also limited to 104 weeks.

Permanent partial disability benefits: Varies by injury, but the weekly benefit amount is subject to the state maximum of $576.20 as of 2018.

Permanent total disability benefits: Equal to two-thirds of your weekly wage, subject to the state's maximum, paid out potentially for life.

Other notable coverage: Surviving dependents are eligible for death benefits equal to two-thirds of the deceased's average weekly wage, subject to a state maximum of $823.14 and up to $7,000 to cover burial expenses.

Wisconsin workers' compensation

Program administrator: Wisconsin Department of Workplace Development

Employers required to provide coverage: Companies employing three or more full-time or part-time employees

Medical benefits: All reasonable and necessary medical expenses related to the disability

Temporary total disability benefits: Equal to two-thirds of your average weekly earnings, subject to the 2018 state maximum of $1,491. There is a three-day waiting period of coverage, with back pay issued if the disability lasts seven days or more. TTD benefits are paid until you return to work, or your condition is no longer expected to improve — you become eligible for permanent disability benefits.

Temporary partial disability benefits: Equal to TTD benefits minus the wages you're making in your modified position, subject to the state max.

Permanent partial disability benefits: Amount and duration of benefits vary by the severity of your injury, but are subject to a weekly ($362), monthly ($1,568.67) and annual maximum ($74,550) as of 2018.

Permanent total disability benefits: Equal to two-thirds of the employee's average weekly wage subject to $1,491 maximum, payable for life.

Other notable coverage: Death benefits vary by relationship. Surviving spouses are entitled to a maximum death benefit of four times the average annual earnings ($298,200 as of 2018), paid out monthly at a corresponding maximum. Dependents can also receive up to $10,000 for burial expenses.

Wyoming workers' compensation

Program administrator: Wyoming Department of Workforce Services

Employers required to provide coverage: All of them, with a few standard exclusions; Unlike most states, Wyoming mandates employers purchase workers' compensation insurance from its state fund. They can't purchase a private plan or self-insure.

Medical expenses: All care directly related to the illness or injury.

Temporary total disability benefits: Equal to two-thirds of your monthly gross income or 30% of the statewide average monthly income ($3,779.75 in 2018), depending on how much you normally earn each month. Payments are made for up to 24 months. You are not paid for the first three days of lost wages, unless your disability lasts eight days or more.

Temporary partial disability benefits: Equal to 80% of the difference between your modified wage and your actual monthly wages prior to your workplace illness or injury.

Permanent partial disability benefits: The length and amount of compensation depends on salary, age, occupation, education and career plans.

Permanent total disability benefits: You can apply for up to 80 months' worth of income replacement. Total compensation varies by salary, age, occupation, education and career plans. Once the 80 months elapses, you must reapply annually to renew benefits.

Other notable coverage: Dependents are eligible for varying death benefits. For instance, a spouse can receive up to 100 months of benefits with total compensation based on a percentage of wages at the time of death compared to the state average. Dependents can receive up to $5,000 in burial expenses.

Types of disability insurance riders

A rider is an add-on that changes your disability insurance coverage. Some riders are free while others cost extra to add. Although riders aren't exactly types of insurance, they can affect how your policy works.

Here are a few common disability insurance riders:

- **Automatic increase rider**: Raises your benefits over a limited number of years without a medical exam.
- **Cost of living adjustment rider**: Increases your monthly benefits to keep pace with inflation.
- **Future increase option**: Allows you to increase your benefits a limited number of times without a medical exam.
- Guaranteed renewable and non-cancelable: Ensures your policy stays active and your rates stay the same as long as you keep paying your premiums.
- **Partial or residual disability rider**: You can receive some disability benefits if an injury or illness affects your income at all, even if you're not unable to work.
- **Rehabilitation waiver**: Helps pay for the cost of physical or occupational rehabilitation after a disability.

- **Retirement protection rider**: Covers the payments that you would have made to a retirement fund while you were working.
- **Student loan protection rider**: Continues your student loan payments while you're out of work.
- **Survivor or death benefit:** Pays a few months of benefits to a surviving beneficiary if you die while receiving disability payments.

What kind of policy is guaranteed-renewable?

Both short and long-term disability insurance policies can be guaranteed-renewable.

Is disability insurance always guaranteed-renewable?

Not necessarily. Although it's more common for coverage to be guaranteed-renewable than conditional, you should always make sure you know what kind of policy you're buying before finalizing your coverage.

Does everyone need to have guaranteed-renewable insurance?

Yes, your disability insurance should be guaranteed-renewable. Otherwise, you can't be certain that you'll be able to use your benefits in the future.

What does guaranteed-renewable disability insurance cost?

Most disability insurance policies are guaranteed-renewable, so you won't need to worry about paying an extra fee to add that to your policy.

Alternatives to disability insurance

Self-insuring can be an alternative to disability insurance. Self-insurance isn't a type of disability insurance, it just means using your savings to cover your expenses while you're out of work.

This is only an option if you have enough money saved up that you can rely on your savings alone while you're not working.

Disability insurance basics

Here are some important terms and phrases to know if you're shopping for disability insurance:

- **Benefit amount**: The amount you'll be paid if an injury or illness keeps you from working.
- **Benefit period**: The length of time that you'll receive payments after a disability. Your benefit period can last a few months, years, or even decades.
- **Claim**: The process of submitting proof of your disability to your insurance company so that you can start to collect your benefits.
- **Definition of disability**: Your policy's rules for what counts as a covered "disability." This can affect whether you can receive any benefits, and how much you can collect.

- **Elimination period**: Also called a "waiting period," this is the amount of time you have to wait between a disabling event or injury and when you can start receiving payments.

You usually get to pick an elimination, or waiting, period when you buy a disability insurance policy. For long-term disability insurance, you can sometimes choose a longer elimination period means cheaper rates, but don't make your elimination period too long, because it may mean going months or even years without an income. Remember that the best way to find affordable disability insurance is by comparing quotes from multiple companies.

Elimination periods for long-term disability insurance range from 30 days to two years, and seven days for a short-term policy.

Your elimination period begins on the day of your disabling event, **not** when you file a claim. So for an illness, that would mean the first day your symptoms keep you from working. Once your elimination period is up, and as long as your condition lines up with your policy's definition of a disability and your claim is accepted, your benefits will start.

How do elimination periods work?

Elimination periods work like this: You can file a claim as soon as you have an illness or injury that keeps you out of work, but you won't start receiving payments until the elimination period is up. So if your elimination period is 6 months, you won't start getting payments until 6 months from the date of your disabling event.

But elimination periods can sometimes be tricky. Depending on how you choose to receive your benefits (meaning your payments), they might not arrive right after your elimination period ends, and you may have to live on your savings for longer than expected.

You only have one elimination period per injury or illness, so if you try to go back to work after a few weeks off but can't, your elimination period won't restart.

It's also possible to skip your elimination period altogether if you have a serious disability, are permanently disabled, or if you have to submit more than one disability claim.

How to you choose an elimination period

When you're choosing an elimination period, consider how long you can afford to live without a paycheck, and any other coverage you have that can pay out while you're waiting.

These steps can help you decide on an elimination period for your disability insurance policy:

- **Do the math**: Calculate your monthly expenses and divide the total by the money you have saved. This will tell you how many months' cushion you have to rely on your savings alone.
- **Account for other forms of income**: If you don't have much in savings, but you have a partner who earns enough money to keep you both afloat while you're out of

work, or you have short-term disability insurance that will pay out right away, you may be able to opt for a longer elimination period for your long-term disability coverage.

How do different elimination periods affect disability insurance rates?

Your elimination period is just one of the factors — along with the amount of coverage you get, your benefit period, and your age — that determines your disability insurance rates. In fact, your elimination period can affect your rates by quite a bit.

We found that the average cost of disability insurance with a 30-day elimination period is almost double the cost of a policy with a 90-day waiting period. An even longer 720-day elimination period is about one third cheaper than a policy with a 90-day waiting period.

Elimination period	Average rate
30 Days	$1,667
60 Days	$1,358
90 Days	$843
180 Days	$713
365 Days	$604
720 Days	$575

Average monthly rates for own-occupation long-term disability insurance with a benefit period through age 65.

Remember that you still have to be able to cover your expenses while you're out of work and not receiving any benefits or income from another source, so don't just choose the longest elimination period you can to get affordable disability coverage**.**

Elimination period vs. probationary period

An elimination period isn't the same as a probationary period in insurance. A probationary period is a set amount of time during which you can't file a claim.

Long-term disability insurance usually doesn't have a probationary period — most disability policies don't. Other types of insurance, like health insurance, typically have probationary periods, but you could file a disability claim the day after your policy starts if you need to, as long as it's not for a pre-existing condition.

- **Rider**: A disability rider is a change or addition to your coverage. Riders can be included or optional — you may have to pay extra to add an optional rider.
- **Premium**: The regular payments you make to keep your disability insurance policy active.

Group Disability Income Policy

- **Description**: Offered by employers, this policy provides disability income benefits to employees.
- **Example**: An employer-provided policy that pays 50% of an employee's salary if they are unable to work due to a long-term illness.

Key Employee Policy

- **Description**: Provides benefits to a business if a key employee becomes disabled.
- **Example**: A policy that pays $100,000 to a company if their top sales executive is unable to work for six months due to a disability.

Group Life Insurance Policy: Defined and Explained

Roughly two-thirds of Americans rely on group life insurance from work. However, nearly half of these people either don't understand or only somewhat understand how it works, according to an Insurance Barometer Study by LIMRA and Life Happens, both industry-funded groups.

What Is Group Life Insurance?

Group life insurance is a single contract that provides coverage to a group of people, typically those who work for the same company. The employer owns the policy, which covers the employees. Your beneficiaries will get a payout if you pass away while covered by group insurance.

The most common group life insurance policy is provided by employers. However, some churches, professional associations, alumni groups, unions and other affiliate organizations offer group life insurance to members.

There are many different formulas used to calculate group life insurance benefits. Some of the the most common types are below.

Fixed multiple-of-earnings benefit plans

These group life insurance plans tie your death benefit amount to a multiple of your wages, such as two times your annual salary. Because the payout is linked to your salary, the level of protection rises as your income increases.

Variable multiple-of-earnings benefit plans

These group life insurance plans' benefits are based on multiples of your earnings at certain thresholds. For example, the death benefit might be equal to your salary if you make under a certain amount, or it might be two times your annual earnings if you make over a certain amount.

Flat-dollar-amount benefit plans

These group life insurance plans pay the same amount to all employees and are a fixed dollar amount. Payouts ranging from $10,000 to $25,000 tend to be the most common.

Variable-dollar-amount benefit plans

Variable-dollar-amount plan payouts can vary based on your earnings and length of service.

What Is the Purpose of Group Life Insurance?

The purpose of group life insurance is to help provide peace of mind for employees and their families, knowing they will have some financial security if the person covered by group life insurance passes away.

Businesses offer group life insurance as a way to help attract and retain talent. For businesses, offering group life insurance can be an effective way to show employees that they're valued and that their well-being is a priority.

For families struggling to make ends meet, group life insurance can be a lifeline. However, one thing you should know about group life insurance is that it often isn't enough on its own. Group life insurance is also sometimes called supplemental life insurance because it's meant to provide additional protection beyond an individual life insurance policy.

Pros and Cons of Group Life Insurance

Although group life insurance is a valuable perk, it has its pros and cons.

Advantages of group life insurance

- Group life insurance is generally less expensive than individual life insurance because your employer pays all or most of the cost.
- It's often easier to qualify for group life insurance because there's no medical exam required—unless you want to buy extra group life.
- Group life insurance is easy to get because you can sign up during employee onboarding or open enrollment.
- You may be able to add coverage for a spouse and/or dependent.

Disadvantages of group life insurance

- If you leave your job, you often lose coverage. The only exception is if your policy is "portable," which means you continue to buy the group life insurance (at your own cost) after you've left the job.
- The death benefit of a group life insurance policy is usually lower than that of an individual policy.

- Most group life insurance policies don't have cash value, which means you can't borrow against it, as you can with permanent life insurance.

Summary: Group life insurance pros and cons

Pros	Cons
Typically free or low cost	Coverage is typically tied to employment
No medical exam in most cases	Low death benefit amounts
Easy to sign up for at work	No cash value

When to Get Group Life Insurance

If your employer offers free group life insurance, it makes sense to opt into it. It usually costs you nothing and will provide a little more financial security to your beneficiaries in the event of your death. Even if you have to pay for group life, it's usually cheaper than an individual life insurance policy.

Beyond that, group life insurance can be a great way to get coverage if you have trouble qualifying for an individual policy due to health issues. This is because the underwriting standards are often more lenient for group policies.

Requirements for Group Life Insurance

To qualify for group life insurance, you must usually be an active employee of the company that offers the policy. Some policies may require that you work a certain number of hours per week to qualify, while others may be available to all employees regardless of status.

Premiums for Group Life Insurance

Premiums for group life insurance are often paid in full or partially by the employer. If you pay a portion it can be deducted from your paycheck. Your premium can depend on factors such as your age, salary and whether you smoke. Your employer may also offer different levels of coverage at different price points, so you can choose how much coverage you want based on your needs and budget.

The Cost of Group Life Insurance

Group life insurance costs vary depending on your employer, the life insurance company and the characteristics of the group, such as the average age of employees. The average cost of group life insurance purchased through an employer is usually quite low.

For example, here's a look at Walmart and Amazon's group life insurance, two of the largest companies in the U.S.

Walmart gives full-time employees company-paid life insurance equal to their annual pay, up to $50,000. Beyond this, hourly associates can pay for up to $200,000 in group life insurance, while salaried associates and drivers can pay for up to $1 million in coverage.

A 40-year-old full-time Walmart employee who does not use tobacco pays $.0295 for $1,000 or $2.95 per biweekly pay period for $100,000 in additional coverage.

These additional premiums are deducted from paychecks.

Amazon gives most part-time and full-time employees free basic life insurance equal to two times their annual salary. Employees have the option to buy additional coverage up to 10 times their base annual earnings.

For example, a 40-year-old full-time Amazon employee will pay $0.059 for every $1,000 of additional coverage. If that employee wants to purchase $100,000 of additional group life insurance, they'd have a monthly premium of $5.90.

B. Accidental Death and Dismemberment

- **Description**: Provides benefits if the insured dies or loses a limb due to an accident.
- **Example**: A policy that pays $200,000 for accidental death and $100,000 for the loss of a limb.

Understanding AD&D Insurance: Benefits & Coverage

Accidents are the fourth leading cause of death in the U.S., and the No. 1 cause of death for adults ages 25 to 44, according to the Centers for Disease Control. Only heart disease, cancer and Covid kill more Americans than accidents.

That's why there is accidental death and dismemberment (AD&D) insurance. But as with all the best life insurance products, it pays to understand what it really covers and if you need it.

What Is Accidental Death and Dismemberment Insurance?

As the name suggests, accidental death and dismemberment insurance provides coverage for a death due to an accident. It generally also pays if you lose a limb or a function such as sight, hearing or speech in an accident.

Typically, the beneficiaries you name on your policy will receive a lump-sum payment if you die in an accident. You can receive what are called living benefits if you are injured, and the amount you receive often depends on the type of injury.

For example, an AD&D policy might pay 50% of the coverage amount you purchase if you lose one thing—for example, a hand, foot or sight in one eye—and 100% if you lose two or more things. And policies might pay 50% to 100% of the benefit amount for paralysis as a result of an accident.

The amount of coverage you can get will depend on limits set by insurers or by employers that offer AD&D insurance as a workplace benefit. For example, you can purchase an AD&D policy from Farmers Insurance with a benefit ranging from $37,500 to $200,000 for an accident covered by your policy. Farmers may also pay $1 million for "certain circumstances," such as losing your life in a plane crash on a commercial flight.

What's Covered by AD&D Insurance?

AD&D insurance will cover only deaths and injuries from accidents—not natural causes or illnesses. Not heart attacks or strokes. Policies typically cover death or injuries from accidents at work, home and while traveling.

In addition, if your death is the result of an accident while traveling on public transportation, including a bus, train or airplane, the payout can be double or triple the amount of your base coverage. To be covered, a death from an accident doesn't have to be instant, but it usually needs to occur within a certain time frame, such as within a few months. The policy will outline the rules.

Are There Additional AD&D Insurance Benefits?

Some insurers will pay an additional benefit if you were wearing a seatbelt during an accident that led to an injury or death. Additional benefits might also be provided to help children pay for higher education. Counseling, legal and financial advising services for beneficiaries can be added benefits for a surviving spouse, too. These options will vary by insurer.

What's Not Covered by AD&D Insurance?

What is considered an "accident" by insurance companies isn't as straightforward as it might seem.

"The definition of accident could be subjective," says Jon Voegele, agency vice president of Country Financial.

Policies tend to have a long list of situations when death or injury won't be covered. Those exclusions can vary from company to company and can depend on the state where the policy is issued. Benefits are generally not payable for:

- Injury that happened prior to coverage
- Death caused by illnesses, including mental illness
- Suicide or self-inflicted injuries
- Drug overdose
- Death or injury while driving under the influence of alcohol
- Death or injury from voluntarily inhaling gas or taking poison
- Death or injury while committing a crime
- Death or injury while participating in a riot or suffered during a war
- Injuries while serving in the armed services

- Death or injury from car racing, flying a plane, playing professional sports or participating in extreme sports such as sky diving and scuba diving

How Can You Get AD&D Insurance?

If you work for a company, there's a good chance your employer offers AD&D insurance as part of its benefits package. Some employer group plans also allow employees to insure their spouse and children.

A few insurance companies, such as AIG Direct, Farmers Insurance and Mutual of Omaha, sell individual AD&D insurance policies. You can also look for quotes online or could work with an insurance agent who can compare policies to find the best one for your needs.

Accidental death coverage can also often be purchased as a life insurance rider, or add-on, to life insurance policies. The coverage can double what your life insurance payout would be if you die as a result of an accident.

Also see: What Is Voluntary Life Insurance?

Cost of AD&D Insurance

The cost for AD&D insurance tends to be lower than rates for traditional life insurance because the coverage is limited to accidents. And if your employer offers AD&D insurance, you might be able to get a basic amount as a free benefit.

In general, AD&D insurance costs are tied to the amount of coverage you purchase. For example, monthly premiums might start at $4.50 for every $100,000 in accidental death coverage from Farmers. Rates start at about $8 a month for $100,000 of coverage from Fabric. Because rates can vary from insurer to insurer, it can pay to shop around for the best rate.

Pros and Cons of AD&D Insurance

Some people mistakenly think that having AD&D insurance is a financial safety net if someone dies unexpectedly. "It gives them a false sense of security," Voegele says. Because AD&D provides limited coverage, it isn't right for everyone.

Pros

You don't have to take a medical exam to get AD&D insurance. And you don't have to answer questions about your health, which can make this type of policy appealing to people with pre-existing conditions that make it difficult to find affordable life insurance.

You won't be denied coverage because of your health. You just have to meet the age requirements. Typically, you must be between ages 18 and 70 or 80.

You can get coverage quickly. Because there are no lengthy questionnaires to fill out, no medical exams to take and no waiting period, you can get approved for a policy within a matter of days or even minutes for some policies purchased online.

Cons

Coverage is limited. AD&D will only pay out if the death or injury was a result of an accident—and there are plenty of ways to die other than an accident. This limited coverage is a big drawback.

Coverage isn't as cheap as it seems. An AD&D policy will cost less than regular life insurance. But that's because the chance of an AD&D payout is relatively low. "The odds of you using it are so far down the scale that it becomes expensive for the payout," Voegele says.

You might lose your coverage if you leave your job. Most people who have AD&D insurance get it through a group plan at work, Voegele says. Often, you can't keep that coverage if you leave your job.

Who Should Get AD&D Insurance?

Because it only pays out in the event of an accident, AD&D insurance isn't ideal for everyone. But don't turn it down if it's offered as a free workplace benefit.

"If it's offered for free, absolutely take it," Voegele says. "If you have to pay for it, I would recommend that one size does not fit all."

In other words, consider the value you get for a workplace policy you'd have to pay for to determine if the coverage you'd get would be worth the cost.

Alternatives to AD&D Insurance

A term life insurance policy is usually better coverage than AD&D insurance because it provides a payout for any cause of death (except suicide, generally within the first two years of having the policy). So accidents, heart attacks, strokes and more are all covered under a traditional term life policy.

If you're young and healthy, you might be able to get a term life policy at a rate that's not much higher than what you'd pay for AD&D insurance.

You'd also be better off signing up for disability insurance through your employer or getting a policy on your own in case you're unable to work. Disability insurance will help replace lost wages if you can't work because of illness as well as an injury.

"I would shy away from accidental death plans because there are so many things that can happen to us that aren't accidents," Voegele says. "You need to be covered for anything."

C. Medical Expense Insurance

Basic Hospital, Medical, and Surgical Policies

- **Description**: Covers basic hospital, medical, and surgical expenses.
- **Example**: A policy that covers hospital stays, surgeries, and doctor visits

Key takeaways:

If you itemize deductions, you can deduct unreimbursed medical and dental expenses that exceed 7.5% of your adjusted gross income (AGI).

The IRS allows you to deduct expenses for many medically necessary products and services, including surgeries, prescription medications, and dental and vision care.

You can't deduct medical expenses that are for general health purposes, like nutritional supplements and vitamins. To qualify as deductions, expenses must be for the purpose of preventing or treating a specific medical condition.

With tax-filing deadlines approaching, you might be trying to figure out the different ways you can lower your income tax bill. One often overlooked opportunity for savings is deducting medical expenses.

Although many people choose to take the standard deduction, if you itemize deductions, you may be able to lower your income tax for the year by deducting certain medical and dental expenses. If you had surgery, were diagnosed with cancer or another serious medical condition, or went through a process like IVF to get pregnant, the high out-of-pocket costs could make you a candidate to claim a medical expense deduction. Some of the expenses that qualify as deductions, such as wigs and LASIK surgery, may even surprise you.

What are the rules for deducting medical expenses?

You must meet certain requirements to be eligible to deduct medical expenses on your tax return.

First, you must itemize your deductions on Schedule A of your tax return, instead of taking the standard deduction. Generally, you'll only itemize deductions if they total more than the standard deduction. You'll want to choose the option that allows you to pay the lowest amount in federal income tax. So if you are a single filer whose standard deduction is $13,850, you'll only want to itemize deductions if they exceed $13,850.

Unfortunately, you won't be eligible to deduct all of your medical expenses on your tax return, even if you do choose to itemize deductions. You can only deduct unreimbursed medical and dental expenses for you, your spouse, and dependent that exceed 7.5% of your adjusted gross income (AGI). It's important to keep all your receipts so you can have proof of your medical expenses if you're audited.

Let's say you have an AGI of $60,000, and your medical bills add up to $15,000 for the year. On your tax return, you can deduct qualified expenses over $4,500 (7.5% of $60,000). That's $10,500 worth of qualifying medical expenses ($15,000 minus $4,500) for the year.

According to IRS Publication 502, you can only classify services or items as medical expenses if they "alleviate or prevent a physical or mental disability or illness." Below are 99 medication expenses you may be able to deduct on your tax return in 2024, organized by category.

Vision services or products

Vision services or products that are used to treat defective vision fall under the category of qualifying medical expenses. This is also true for contact lenses and related products. Below are 11 vision expenses you may be eligible to deduct in 2024:

- Braille books and magazines used by visually impaired people
- Contact lenses
- Contact lens cases
- Enzyme cleaner

- Eye drops
- Eye exams
- Laser eye surgery
- Prescription eyeglasses
- Prescription sunglasses
- Radial keratotomy
- Saline solution

If your dental expenses are not covered by insurance, they may be tax deductible if they help prevent or alleviate dental disease. Below are 14 dental expenses that you may be able to deduct:

- Application of sealants to prevent tooth decay
- Braces
- Crowns
- Dental bridges
- Dental checkups
- Dental X-rays
- Dentures
- Extractions
- Fillings
- Fluoride treatments to prevent tooth decay
- Gum surgery
- Invisalign products
- Root canals
- Teeth cleanings to prevent tooth decay

Medications that are prescribed by a healthcare professional also count as qualifying medical expenses. This is also true for insulin that's not prescribed by a healthcare professional. Below are 13 of the most commonly prescribed medications that may be tax deductible.

- Antidepressants
- Escitalopram (Lexapro)
- Fluoxetine (Prozac)
- Paroxetine (Paxil)
- Sertraline (Zoloft)

- Medications for chronic weight management
- Saxenda (liraglutide)
- Wegovy (semaglutide)
- Zepbound (tirzepatide)
- Medications for erectile dysfunction
- Sildenafil (Viagra)
- Tadalafil (Cialis)
- Stendra (avanafil)
- Type 2 diabetes medications
- Mounjaro (tirzepatide)
- Ozempic (semaglutide)
- Trulicity (dulaglutide)

You may be able to deduct the following 10 expenses related to family planning and fertility treatments:

- Birth control pills prescribed by a healthcare professional
- Breast pumps
- In vitro fertilization (including temporary storage of sperm or eggs)
- Legal abortion
- Milk storage bags
- Nursing pads
- Pregnancy test kits
- Tubal ligation
- Vasectomy
- Vasectomy reversal

You may be able to claim health insurance premiums on your tax return depending on how much you spent on medical care, how you paid for premiums, and if you were self-employed. But you cannot deduct any expenses that were reimbursed by an insurance plan, flexible spending account (FSA), health savings account (HSA), or any other tax-advantaged savings account.

If you paid for any of these nine types of insurance premiums with after-tax dollars, they may be deductible:

- Dental insurance
- Long-term care insurance (up to an annual limit)

- Medical insurance through the ACA marketplace
- Medicare Part A
- Medicare Part B
- Medicare Part C
- Medicare Part D
- Medigap
- Vision insurance

If you were self-employed during the year, you may be eligible to claim the self-employed health insurance deduction for premiums you paid out of pocket, even if you claim the standard deduction on your taxes. The deduction allows you to claim up to 100% of the premiums you paid for yourself, your spouse, your dependents, or your eligible adult children.

If you have a disability and needed to make certain accommodations to your home, you qualify to deduct costs for the following six items as medical expenses:

- Grab bars in a bathroom
- Lowered kitchen cabinets
- Moved electrical outlets
- Outdoor wheelchair lifts (porch lifts)
- Ramps to get in and out of your home
- Widened doors and hallways

Here is a list of 36 additional items that you may be able to deduct as medical expenses in 2024:

- Acupuncture treatments
- Ambulance services
- Annual physical exams
- Artificial limbs
- Bandages
- Blood sugar test kits
- Breast reconstruction surgery
- Body scans
- Car modifications designed for people with disabilities
- Chiropractor services for medical care
- Copays

- Crutches
- Guide dog trained to assist visually impaired or hearing disabled people
- Hand sanitizer for preventing the spread of COVID-19
- Hearing aids
- Inpatient care at a hospital
- Lab fees
- Masks for preventing the spread of COVID-19
- Nursing home costs, including lodging and meals
- Organ transplant
- Osteopath services for medical care
- Oxygen to relieve breathing problems caused by a medical condition
- Oxygen equipment
- Medical conference attendance
- Psychiatric care
- Substance use disorder treatment
- Services from a Christian Science practitioner for medical care
- Therapy received as medical treatment
- Transportation to another city for medical services
- Treatment at a health institute, if certain requirements are met
- Visits to a psychologist for medical care
- Weight-loss programs to treat heart disease, hypertension, or certain other conditions
- Wheelchairs
- Wheelchair maintenance services, like battery or tire replacement
- Wigs that are considered medically necessary
- X-rays

What medical expenses are not tax deductible?

You are not allowed to deduct expenses that are for general health purposes, such as gym memberships, vitamins, and diet food. You also cannot deduct payments for future medical and dental services.

Below are some other services and items that are likely not tax deductible:

- Deodorant
- Diapers
- Face-lifts
- Hair transplants
- Health club dues
- Health beverages
- Herbal supplements
- Insurance premiums paid by your employer
- Liposuction
- Nicotine patches and gum that don't require a prescription
- Nonprescription medications
- Nutritional supplements
- Surrogacy expenses
- Toothpaste
- Travel to and from work

The bottom line

If you itemize deductions, you may be able to deduct medical and dental expenses that have not already been reimbursed. To qualify as deductions, expenses must be related to the prevention or treatment of a specific medical condition. The total expenses must exceed 7.5% of your AGI if you want to deduct them on your tax return.

Major Medical Insurance: What Is It?

Major medical insurance offers comprehensive coverage, which most of us have come to expect from health insurance. It covers most medical services and procedures, from doctor visits to hospital stays, surgeries and prescription drug coverage.

Most insured Americans have major medical insurance, but it's not the only type of health insurance available. If you're considering purchasing health insurance, it's important to clearly understand what major medical insurance—and its alternatives—offer to you.

What Is Major Medical Insurance?

People looking for medical coverage often want the best health insurance at the most affordable price. Major medical insurance is likely the most attractive option.

Major medical insurance is the type of coverage typically offered through a workplace and the Affordable Care Act (ACA) marketplace. This type of insurance covers the majority of health care services and procedures you might encounter in a given year, including:

- Preventive care
- Emergency room care
- Urgent care
- Outpatient care
- Mental health
- Labs and tests
- Prescription drugs
- Surgery and other procedures
- Hospital care

By contrast, other types of health care coverage usually aren't as comprehensive. For example, short-term health insurance generally provides coverage for up to a year with the chance to extend for two more years in most states. Short-term plans offer lower premiums but higher out-of-pocket costs when you need care, fewer benefits and consumer protections than major medical health insurance.

Hospital indemnity plans are another type of health coverage. Indemnity plans offer a fixed benefit paid directly to you when you require hospital care. But this type of insurance doesn't cover standard medical care and is meant to supplement—rather than replace—health insurance.

What Major Medical Insurance Covers

One of the hallmarks of major medical insurance found on the ACA marketplace is that it covers 10 essential health benefits as defined by the federal government. Private health insurance in group health insurance offered by employers also often covers these services.

The essential health benefits include:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Pregnancy, maternity and newborn care
- Mental health and substance use disorder services
- Prescription drugs

- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services

Health plans in the ACA marketplace must also provide birth control and breastfeeding coverage, though they're not specifically listed under the essential health benefits.

Types of Major Medical Insurance

There are various ways to get major medical insurance, including:

ACA marketplace health insurance

This type of health insurance is available to individuals and families who cannot get affordable coverage through an employer. Private health insurance companies offer this type of comprehensive health coverage.

You can purchase individual and family insurance plans at the federal and state health insurance marketplaces. People who qualify for advanced premium tax credits and subsidies may pay less for an ACA plan. Only ACA plans provide those household income-related discounts.

Employer-sponsored health insurance

Most working Americans get their medical coverage through group health insurance coverage from an employer.

In many cases, employer-sponsored health insurance offers the most affordable and comprehensive health insurance option. Employers typically pay more than half of premiums costs, which makes it cheaper for employees.

Employees paid an average of $1,327 per year ($111 per month) for health insurance through an employer, while businesses paid an average of $6,584 annually, according to Kaiser Family Foundation's 2022 Employer Health Benefits Survey.

COBRA

If you have coverage in a major medical plan at work and then leave or lose your job, COBRA insurance is an option for extending your coverage for a period, usually 18 to 36 months.

COBRA provides the same coverage you had with the employer plan, but you're responsible for the full premium costs instead of splitting them with your provider. This can make COBRA coverage quite expensive.

Medicaid

Medicaid is a federal/state health insurance program primarily for low-income Americans and eligible children, pregnant women, the elderly and those with disabilities. Medicaid costs are based on your income.

Medicare

Medicare is the federal health insurance program primarily serving adults 65 and older. It also offers coverage to younger people with specific disabilities and those with end-stage renal disease.

Student health plans

This type of health insurance is typically available to college students, but many students don't need this type of coverage, as federal law lets them remain on their parent's health insurance plan until they turn 26.

Who Needs Major Medical Insurance?

Just about everybody needs major medical insurance. Perhaps those who are independently wealthy can self-insure. But if that's not you, major medical insurance is essential. It provides preventive care and can help you avoid financial ruin if you're hospitalized or develop a life-threatening or chronic health condition.

Some people skip major medical insurance and choose short-term insurance simply because it's cheaper and they only want to bridge a short coverage gap. But you never know when your health will take a turn for the worse.

If that happens, major medical insurance can offer comprehensive coverage that saves you thousands of dollars.

How Much Does Major Medical Insurance Cost?

The average health insurance cost per month is $928 for a Bronze ACA plan. The average monthly costs increase to $1,217 for a Silver plan and $1,336 for a Gold plan. Those averages don't consider premium tax credits and subsidies that can reduce costs for an ACA plan based on household income.

Health insurance companies set rates for ACA plans by age, plan type, metal tier and tobacco use. They can't use gender or where you live.

Here's the average cost by age.

Average cost of health insurance by age

A plan's benefit design dictates such things as whether you can get out-of-network care and whether you need referrals to see specialists. Health maintenance organization (HMO) and exclusive provider organization (EPO) plans are typically cheaper than preferred provider organization (PPO) plans. Here's the average cost by plan type.

How to Get Major Medical Insurance

There are many ways to get major medical insurance:

1. Through your employer. If your workplace offers group coverage, this is often the best and most affordable way to get coverage.

2. Through the ACA marketplace. Going to a federal or state health insurance marketplace is one way to get coverage if you can't get it at work. These plans offer tax credits and subsidies if your household income qualifies.

3. Directly through an insurer or a website. You also can purchase directly from a health insurer or may be able to buy through a third-party website.

4. Through Medicaid. If you qualify, you can get coverage through this program, which is a joint effort between the federal government and individual states.

5. Through Medicare. If you are 65 or meet other criteria, you can get coverage through this federal program.

6. Through a college or other institution of higher learning. Students often can get coverage this way.

Major Medical Health Insurance vs. Short-Term Health Insurance

Major medical insurance provides more comprehensive coverage and better consumer protections than short-term insurance.

Two benefits of short-term insurance are that it's much cheaper than major medical insurance, and you can buy it anytime during the year.

Major Medical Health Insurance vs. Hospital Indemnity Insurance

Hospital indemnity insurance is not a form of standard health insurance. Rather, it's intended to supplement your primary insurance policy.

While major medical insurance covers most types of health care services and procedures, hospital indemnity insurance pays you if you're in the hospital for an extended period. It doesn't offer coverage for other types of medical services.

Health Maintenance Organizations (HMOs)

- **Description**: Provides health services through a network of providers for a fixed annual fee.
- **Example**: An HMO plan that requires members to choose a primary care physician and get referrals for specialists.

Preferred Provider Organizations (PPOs)

- **Description**: Offers more flexibility in choosing healthcare providers and does not require referrals.
- **Example**: A PPO plan that allows members to see any doctor without a referral but offers lower costs for in-network providers.

Point of Service (POS) Plans

- **Description**: Combines features of HMOs and PPOs, requiring a primary care physician but allowing out-of-network care at a higher cost.
- **Example**: A POS plan that covers out-of-network visits but at a higher copayment.

Flexible Spending Accounts (FSAs)

- **Description**: Allows employees to set aside pre-tax dollars for medical expenses.

- **Example**: An FSA that lets employees use pre-tax dollars for prescriptions and doctor visits.

High Deductible Health Plans (HDHPs) and Health Savings Accounts **(HSAs)**

- **Description**: HDHPs have higher deductibles but lower premiums, and HSAs allow pre-tax savings for medical expenses.
- **Example**: An HDHP paired with an HSA that lets employees save pre-tax dollars for future medical expenses.

Health Reimbursement Accounts (HRAs)

- **Description**: Employer-funded accounts that reimburse employees for medical expenses.
- **Example**: An HRA that reimburses employees for out-of-pocket medical costs.

What is Medigap?

Your guide to Medicare supplement insurance

What Medicare supplement plans cover, when you can enroll if you're eligible, and what you can expect to pay for coverage

What is Medigap?

Medigap, also known as Medicare supplement insurance, is an insurance policy that supplements Original Medicare. It's designed to cover some or all of the out-of-pocket costs that a beneficiary would otherwise have to pay for services covered by Original Medicare.

Original Medicare does not have a cap on out-of-pocket costs, and most people have supplemental coverage. Only 8% of Medicare beneficiaries rely solely on Original Medicare. So when you're enrolling in Medicare, you can either choose Original Medicare plus a Medigap policy (and a Medicare Part D prescription drug plan if you don't have other prescription coverage), or a Medicare Advantage policy. You can't use (and don't need) a Medigap policy in conjunction with a Medicare Advantage plan.

What is the difference between Medicare Advantage and Medicare supplement (Medigap)?		
	Medigap	**Medicare Advantage**
Is there an annual plan change opportunity?	Not without medical underwriting, unless you're in a state that requires it.	Yes, during the Annual Election Period and Medicare Advantage Open Enrollment Period.

What is the difference between Medicare Advantage and Medicare supplement (Medigap)?		
Is coverage guaranteed-issue?	Yes, during your Medigap open enrollment period (six months, starting when you're 65 and enrolled in Medicare Part B). In most states, no, after your initial enrollment period has ended. If you're under 65, this varies by state.	Yes. (Note that you can enroll when you're first eligible or during the Annual Election Period. You can also make a plan change during the Medicare Advantage Open Enrollment Period. Outside of those windows, you generally cannot enroll in a Medicare Advantage plan without a special enrollment period.
How high are out-of-pocket costs?	This varies by plan. For new enrollees, it can be as low as just the $240 Part B deductible (with Plan G), but less comprehensive plans can result in higher out-of-pocket costs. (Note that this does not include prescription costs.)	Out-of-pocket costs can be as high as $8,850 for in-network benefits, although the average is less than $5,000. (Note that this does not include prescription costs.)
How high are premiums?	Varies by plan and location.	Varies by plan and location, but the average premium in 2023 was about $18/month (in addition to the cost of Part B). About two-thirds of enrollees are in plans that have no premium other than the cost of Part B.
What medical providers can you see?	With the exception of Medicare SELECT, Medigap plans cover any providers who accept Medicare, nationwide. Medigap plans are not managed care plans, so you will not see them labeled as HMOs, PPOs, etc.	Plans create their own provider networks, which can be local or national. Plans can limit care to in-network providers (HMOs, for example), or give the option to see out-of-network providers at a higher cost (PPOs, for example).

What is the difference between Medicare Advantage and Medicare supplement (Medigap)?		
Are prescription drugs covered?	No. Medigap plans sold after 2005 do not include prescription coverage, so enrollees need separate coverage for that.	89% of all Medicare Advantage plans include prescription coverage.
Are plans available in all areas of the U.S. and its territories?	Plans are available throughout the U.S., although the number of available plans varies from one area to another. Plans are not available in the U.S. territories.	Plans are available in nearly all areas, although 68 rural counties have no Medicare Advantage plans available in 2024. There are also no Medicare Advantage plans available in Guam, the Virgin Islands, American Samoa, or the Northern Mariana Islands, although there are Medicare Advantage plans available in Puerto Rico.

What is Medigap coverage used for?

Medigap coverage will pay various medical bills that Original Medicare beneficiaries would otherwise have to pay themselves. Original Medicare includes Medicare Part A, for inpatient care, and Medicare Part B, for physician services and outpatient care. Both parts have out-of-pocket costs, and there is no limit on how high those costs can be:

- Medicare Part A has a deductible for each benefit period, plus daily charges that begin to accrue after 60 days in the hospital or after 20 days of a covered skilled nursing facility stay.
- Medicare Part B has an annual deductible, and then 20% coinsurance for all covered services. (Certain preventive care is fully covered, without a deductible or coinsurance.)

What is the difference between Original Medicare and Medicare Advantage?

Original Medicare vs. Medicare Advantage: a comparison*

	Original Medicare	Medicare Advantage (MA)
Also known as	Traditional Medicare	Medicare Part C
Enrollment through	**Federal government:** Centers for Medicare & Medicaid Services (CMS)	Private carriers
What's covered?	Medicare Part A covers inpatient hospital stays, skilled nursing facility care, hospice care and some home health care. Medicare Part B covers medically necessary services and preventative services, including doctors visits, outpatient hospital stays and medical equipment.	Combines Medicare Part A and Medicare Part B and usually also includes Medicare Part D prescription drug coverage plus additional benefits described below.
Availability	Nationwide	Sold in most but not all counties.
Outpatient prescription drug coverage	Not included. (**Exception:** When administered by injection/infusion in medical office.)	Included in most plans.
Dental & vision	Not included	Included in most plans
Monthly premium cost	No Part A premium for most enrollees Part B premium of $174.70/month in 2024 for most enrollees	Average premium projected to be $18.50/month in 2024. You'll pay this in addition to your Original Medicare premium. **Note:** In 2023, 73% of Medicare Advantage enrollees paid no MA premium, and only paid the Medicare Part B premium.
Cap on out-of-pocket costs	No	**Yes:** In-network out-of-pocket costs can't exceed $8,850 in 2024 (not including prescription drug costs).
Nationwide access to physicians	Yes	Access varies plan to plan. Some MA plans have narrower networks – with fewer physicians in their county.
Will you need to buy additional supplemental coverage?	Probably. Most people buy supplemental insurance due to the lack of prescription drug coverage, dental, vision, and cap on out-of-pocket costs.	Probably not, because most Medicare Advantage plans include coverage for prescription drugs, dental, vision, and cap on out-of-pocket costs.

medicare resources .org

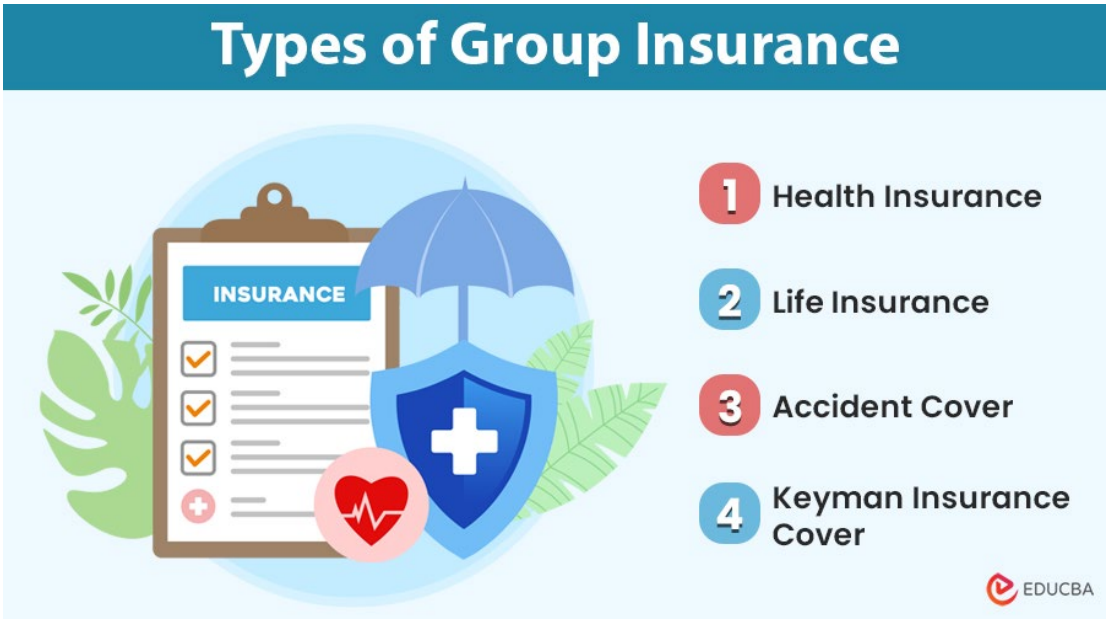
*Complete infographic information available at medicareresources.org/compare

E. Group Insurance

Differences Between Individual and Group Contracts

a. **Description**: Group insurance is provided to a group of people under a single contract, usually through an employer.

4. **Example**: An employer-provided health insurance plan versus an individually purchased plan.



5. General Characteristics

a. **Description**: Group insurance typically offers lower premiums and simplified underwriting.

b. Example: A group life insurance policy that does not require medical exams for coverage.

Definition of Group Insurance

Group Insurance refers to insurance coverage that covers an entire set of people which can be of a particular group, company, or any other associated entity which makes them a group with a common identity.

In short Group Insurance is a collective insurance coverage with a standardized product for all its group members and comprises a single policy being issued instead of a policy to each member of the group. Group Insurance is a common feature in Employer-Employee groups or the case professional groups. However, it is not confined to these groups and can be for any group with a common link between them.

Explanation

It involves multiple groups of members governed by a single policy with the premium amount either paid by the group head which in the case of employer-employee is the employer itself or may involve premium contributed by its group members. It remains

valid for group members as long as they are part of the group and the benefits cease to exist if one leaves the group.

Characteristics of Group Insurance

Some of the common characteristics are enumerated below:

- Group Insurance involves the issuance of a single master policy covering all the group members with a separate Identity card issued to each group member.
- Usually economical compared to individual policies of the same terms and conditions.
- It is standardized and non-customized and follows a one-fit approach.
- It is usually covered under Heath and Life Insurance.

How Does Group Insurance Work?

The working is quite simple and straight forward and unlike normal insurance where every individual is provided a customized policy, it involves a direct master agreement between the Insurance Company and the Employer Organization related to terms of the policy and coverage and premium amount.

In case the premium is fully payable by the Employer the whole premium amount is directly paid by the Employer to the Insurance Company and each group member is provided with a unique Health Identity Card through which the benefits can be availed. In case the premium is payable by the Employee, the amount of premium is debited by the employer and collectively paid to the Insurance Company and the remaining procedure remains the same.

Example of Group Insurance

ABC Limited provides legal consultancy to its clients on matters of Intellectual property rights. Due to the inherent scope of work leading to various contingent liabilities and suits clients can file in case of issues in the discharge of the duties, ABC limited has taken Public Liability Insurance for all its employees which safeguards them from any lawsuit filed by its clients while discharging their responsibilities and any financial claim in future.

Types of Group Insurance

There are various types that are available catering to various needs of the group which can be based on health, life cover, retirement benefits, and liability assurance as well as related to compensation liability, etc; however, the major types are enumerated below:

- **Group Health Insurance:** The most common and prevalent Group Insurance covers the medical and health-related expenditure cost for a group with standardized features and a fixed sum assurance for group members (In some cases the sum assured varies based on the particular grade of employees, other features being equal).
- **Group Life Insurance:** Usually this is provided by the employer to its employees as a life cover under which a fixed amount is paid in case the employee dies while discharging his/her duties. The premium is either paid by the employer or collected from employees and paid collectively by the employer to the insurance company.

- **Group Accident Cover:** This type of scheme is usually provided to cover any injury and loss of life on account of an accident during employment. Normally this type of premium is payable by the employer.
- **Group Keyman Insurance Cover:** This is a late entrant, however, its importance is ever increasing. Normally the key officials in certain industries such as Banking, the Medical profession, and the legal profession take professional decisions in their day-to-day business affairs which can have serious financial implications if things went awry. As such this type of is taken by the employer to limit the financial liability of such key men while they discharge their professional responsibilities independently without the fear of financial failure.

Importance of Group Insurance

It is very important and a necessary part of the benefits offered as part of remuneration in the Service Agreement. Its relevance and utility is not just confined to Employer-Employee relation but can be observed in all types of group setups which includes Non-Employee as well

Further, it helps in providing better and customized benefits to a large group at an economical cost which leads to the better financial and economic well-being of group members.

Benefits

It offers multiple benefits. A few of them are enumerated below:

- It provides medical, and life benefits at an economical cost to group members.
- It acts as a supplement for an employer to attract the right talent. Normally it has been observed that employees prefer companies that provide group insurance.
- It helps companies to save costs as they have a larger pool and can negotiate better with Insurance companies.
- It also provides a tax benefit to employers and results in lowering the tax outflow of the company as group Insurance expenses are tax-deductible.
- In most cases, the group insurance doesn’t require medical tests which are required in the case of Individual Insurance.

Limitations

Despite various advantages, there are certain disadvantages as enumerated below:

- It provides a standardized product that is based on size fit all strategy and may not be a good fit for many group members. For instance, an employer providing a health cover of $10000 for its employees may be sufficient for your employees but not much for employees in a higher age bracket.
- It ceases to exist once the group member leaves the group. In the case of the employment contract, the group insurance ceases to exist once the employee leaves the organization.

Long-Term Care Insurance: What You Need to Know

According to the Administration for Community Living, adults who are 65 years old today have nearly a 70% chance of needing some type of long-term care service and support at some point in their later years[1]. Long-term care—which can take many forms to address an individual's needs for assistance with activities of daily living (ADLs)—can be expensive, and most private health insurance plans don't cover it. For this reason, some older adults decide to enroll in a long-term care insurance plan.

Read on to learn more about what long-term care insurance is, how it works, what it covers and more.

Types of Long-Term Care Insurance Policies

There are two ways to purchase long-term care insurance, according to Georgia-based insurance broker Robyn Pate. An individual can either purchase an independent long-term care insurance policy from their preferred insurance provider, or they can purchase long-term care coverage as part of a life insurance plan.

Both plans require premium payments so long as the policy is active, and the policyholder submits a claim whenever they need to use the coverage. And in both types of plans, the policyholder chooses the amount of coverage they want, which often affects the cost of the plan's premium. Most policies cap the amount they would pay out in benefits per day should the policyholder need to use those benefits. They also cap how much the policy can pay out in benefits during the policyholder's lifetime.

How Does Long-Term Care Insurance Work?

Regardless of the type of plan a person chooses, a health care provider must prescribe long-term care assistance in order for a long-term care insurance policy to cover its portion of the costs, says Pate. If the individual has a standalone policy, it's more likely that the insurance provider will pay a home care agency or skilled nursing facility directly on their behalf. There are some standalone policies that will pay the individual directly.

With most policies, the policyholder is required to pay for the long-term care services they need through what's called the "elimination period," which usually lasts 30, 60 or 90 days. After this period, the insurer providing the long-term care policy starts reimbursing them up to the maximum daily amount provided by their coverage until they reach the full lifespan of the policy.

What Does Long-Term Care Insurance Cover?

A long-term care policy helps cover the costs of a person's care when they need help navigating ADLs due to a chronic medical condition, disability or disorder. To receive long-term care benefits under most policies, an older adult must require help within at least two ADL areas: bathing, eating, dressing, navigating the bathroom and getting in and out of a bed or chair. A health care provider must also predict that they will require this level of help for more than 60 days.

If the long-term care plan is a part of a life insurance policy, the plan will typically pay 2% of the death benefit toward the monthly cost of long-term care for three to five years,

according to Pate. For example, if someone purchased a $100,000 life insurance policy, they would receive up to $2,000 per month for three to five years for use toward the cost of their care. The amount could be applied to care provided in a skilled nursing facility, an assisted living community or their own home. The policyholder could also elect to use the money as they wish, opening the possibility of paying a family member to provide care.

While $2,000 may sound generous, extended long-term care can be expensive. Nationally, skilled nursing facilities charge over $90,000 per year for a shared room, the median cost of assisted living is around $54,000 per year, and the median cost of a full-time home health aide hired through a home health care agency exceeds $61,000 per year.

Some long-term care insurance providers deny coverage to those with preexisting chronic illnesses and conditions. However, these people shouldn't be deterred from seeking out long-term care insurance, says Pate, adding that they'll likely pay more for a plan, but the coverage would still be beneficial should they need long-term care services in the future.

How Common Is Long-Term Care Insurance?

Long-term care insurance has gained popularity since its introduction in the 1980s, due to the likelihood of needing higher levels of care at some point in one's later years and the rising costs of care. The U.S. Department of Health and Human Services states that, on average, women tend to need care longer (3.7 years) than men (2.2 years), with a combined average of three years. While 30% of older adults won't require any long-term care at all, it's estimated that 20% will have care needs that extend beyond five years.

With that said, long-term care policies aren't as widely used as one might expect. As of 2020, roughly 7.5 million U.S. adults have long-term care insurance, according to the American Association for Long-Term Care Insurance[2]. More specifically, only 7% of U.S. adults over the age of 50 have a long-term care insurance policy[3].

How Much Does Long-Term Care Insurance Cost?

Premiums for long-term care insurance policies vary based on the person's age and health status when they apply for coverage, gender and marital status. The cost also depends on the amount of coverage the person wants to purchase and the company providing the policy.

Long-term care policies tend to be less expensive the younger and healthier the person is when they purchase the policy. However, Pate says most people don't think about adding long-term care insurance until they reach 62 years old. A long-term care insurance policy for an average 62-year-old costs approximately $300 per month, she says.

Pros and Cons of Long-Term Care Insurance

Pros	Cons
• Should you need long-term care, a policy can offset a considerable amount of the costs associated with that care, providing some protection for your financial assets as you age. • Some plans allow you to choose where you receive your care, empowering older adults who want to remain at home to continue aging in place with hired assistance. • Depending on your coverage, if you choose to receive care at home, you can choose to hire and pay family members for their assistance instead of hiring someone from a home health agency.	• The premium costs of a long-term care insurance policy may exceed the monthly (or annual) budget of some older adults. • Some plans only pay for long-term care provided in a facility rather than including at-home options. • Some providers deny coverage to those with preexisting conditions or illnesses. • Some plans have an elimination period during which the policyholder is still responsible for the total cost of their care.

What Is Vision Insurance?

Vision insurance helps pay for eye exams, glasses and contacts and may offer discounts for other types of services like LASIK surgery.

Vision insurance is typically not part of health insurance, so you have to buy separate vision insurance coverage. You can buy coverage directly from insurance companies, or vision insurance may be part of an employer's benefits package.

What Does Vision Insurance Cover?

Vision insurance typically covers an annual eye exam and may help pay for glasses once a year or every other year. Here's a list of services and products often covered by vision insurance:

- Annual eye exam
- Allowance for glasses, either annually or every other year
- Allowance for contact lenses, often annually
- Lens enhancements like anti-glare, blue light reduction coatings, scratch resistance coatings and UV protection
- Bifocals and trifocals

- Discounts for glasses and/or contact lenses over the policy allowance

What Doesn't Vision Insurance Cover?

Vision insurance doesn't cover laser surgeries to correct vision—including photorefractive keratectomy (PRK) and LASIK. Those surgeries are considered elective surgery. Vision insurance policies often provide discounts at participating locations for those services.

What to Look for in a Vision Insurance Plan

Consider the following factors when comparing vision insurance plans and looking for the option that best fits your needs.

Wide coverage

When it comes to vision insurance, it's easiest to get coverage from a plan that is offered in every state and has an extensive number of doctors within the provider network. In fact, it's more convenient and helps prevent gaps in coverage if you move or need care while traveling.

Low monthly premiums

Pricing varies based on your plan and coverage levels. It's important to consider your budget when looking for a new vision insurance plan and avoid pricier vision plans if you don't need a high level of coverage. For instance, a generous frames allowance may not be needed if you don't need glasses, but that allowance may be a vital part of a plan if you have glasses.

Full or partial coverage of annual eye examinations

Vision insurance covers annual eye examinations, but not all vision insurance companies cover these exams completely. Vision insurance policies also typically require a copay for eye exams, but our research found that EyeMed Healthy does not have a copay for exams.

Eyewear and contact lens allowances

Whether you need glasses or contacts now or in the future, understand the allowances provided by your vision insurance plan for these expenses. Vision insurance covers frames for glasses and contact lenses up to a specified dollar amount, such as $150 or $200. A plan may require that you only get one allowance per year, and you have to choose between contacts and frames. If you exceed the amount, the policy may offer a discount on the rest of the costs.

Ease of access

Accessibility is important when researching and enrolling in a vision insurance plan, as well as when you need to file a claim or reach a customer service representative. Reading reviews can give you a helpful idea of how responsive the vision insurance company you're considering is in times of need—not just when you're trying to sign up for coverage.

Things to know about your insurance if you have cancer

If you have cancer, it's important to understand your health insurance's Summary of Plan Benefits (SPB) to understand covered and excluded services.

Many insurance companies require pre-authorization for cancer services. Here are some things you might want to check your insurance coverage for:

- Cancer tests such as PET/CT scans, blood tests, bone scans, and other procedures.
- Inpatient and outpatient care including screening, tests, and treatment.
- Cancer therapies such as chemotherapy, radiation, or outpatient infusion) and clinical trials.
- Routine cancer screening or diagnostic test coverage might be different depending on if they are considered "routine" versus "diagnostic."
- Genetic screening or testing to check your cancer risk or find the best treatment.
- Medical equipment such as a cane, walker, hospital bed, or lymphedema supplies (also called Durable Medical Equipment or DME).
- Disposable Medical Supplies like gloves, needles, saline flushes, or dressing kits. Health insurance plans might have different coverage for disposable supplies than for DME.
- Wigs may be covered if your doctor writes a prescription for a "cranial or hair prostheses."
- Nutritional supplies such as nutritional supplements or feeding supplies.

What Is Critical Illness Insurance?

Critical illness insurance is a form of supplemental health insurance that provides coverage for expenses that your health plan doesn't cover. The purpose of critical illness insurance is to provide a monetary safety net in the event of a medical diagnosis that could result in expensive treatments or other financial hardships.

You can generally get critical illness insurance through an employee benefits program at work or by buying an individual policy on your own.

How Does Critical Illness Insurance Work

Critical illness insurance kicks in after you've been diagnosed with a critical illness that the policy covers, such as cancer. You'll typically get a lump sum, such as $25,000 or $50,000, when you're diagnosed with a critical illness.

You can use the money for any reason. That may include:

- Helping pay for your care.
- Paying your health insurance deductible or copayments.
- Reducing your mortgage.

- Paying for childcare.
- Paying for living expenses.

Supplemental critical illness insurance works differently than a traditional health insurance plan. Your regular health insurance plan covers the costs of your healthcare. If you're diagnosed with a critical illness, you can also file a claim with your critical illness insurance company. Your critical illness insurance company provides a lump sum payout up to your policy's coverage limit.

Critical illness insurance can be a good investment for people with a high deductible health plan and large out-of-pocket health insurance costs. Or, if you have a family history of certain health conditions, like cancer or heart disease, critical illness insurance can provide financial peace of mind that you will get financial help if you're diagnosed with the condition.

Because critical illness insurance offers coverage for a wide range of conditions, it can also be beneficial for people who don't have an emergency fund or are concerned about the financial consequences of an unexpected medical diagnosis.

What Does Critical Illness Insurance Cover?

Critical illness insurance provides benefits if you get diagnosed with a qualifying medical condition. The illnesses covered by a policy vary depending on your plan.

Here are some of the critical illnesses that are usually covered under this type of insurance:

- Cancer, though it might get limited to a life-threatening diagnosis.
- End-stage renal failure.
- Heart attack.
- Major organ transplant.
- Multiple sclerosis.
- Parkinson's disease.
- Stroke.

Make sure to dig into the coverage for a policy. Critical illness insurance policies can vary. For instance, some plans cover Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease) and hearing loss, while other policies don't cover those health issues.

Does Critical Illness Insurance Cover Pre-Existing Conditions?

Most critical illness plans don't cover pre-existing conditions that were diagnosed before the policy was purchased.

For example, your critical illness plan may not provide benefits if you were diagnosed with coronary artery disease before getting critical illness insurance and later needed bypass surgery.

What Does Critical Illness Insurance Not Cover?

Check your policy for specific exclusions, but a critical illness insurance policy generally won't cover:

- Asthma.
- Diabetes.
- Injuries sustained in an illegal act.
- Injuries sustained by substance abuse.
- Injuries sustained in war.
- Pre-existing conditions, though a critical illness insurance policy may cover the condition after a certain time period, such as one year after purchase.
- Self-inflicted injuries.

Advantages of Critical Illness Insurance

- **Provides financial help if you get sick:** A critical illness insurance plan can offer financial protection for your family. This type of insurance can also keep you financially stable while you pay for treatment.
- **Benefits can be used for anything:** The payout from a critical illness insurance plan goes directly to you and can be used for any purpose, not just medical costs. If you need to pay for childcare or catch up on mortgage payments, for example, the proceeds can cover those expenses.
- **Affordable premiums:** Most critical illness insurance plans are relatively affordable, especially compared to the cost of health insurance. Purchasing a plan can supplement your existing health insurance without raising your overall monthly health insurance premium significantly.

Drawbacks of Critical Illness Insurance

- **Low coverage limits:** Critical illness insurance plans generally offer low benefits. For example, many companies provide maximum coverage limits of $50,000. Depending on your financial situation and the cost of treatment, this may not cover most of your expenses.
- **Doesn't cover pre-existing conditions:** If you have pre-existing health conditions, your critical illness insurance policy probably won't cover them. Many plans also exclude coverage for new critical conditions that resulted from previous diagnoses.
- **Premiums increase with age:** The cost of critical illness insurance usually increases as you get older. Some policies allow you to lock in a lower rate while you're younger, while others increase rates as you age. If you're buying a policy, check with the insurer about whether the costs will increase or if you're locked in with that rate for the life of the policy.

How Much Does Critical Illness Insurance Cost?

The cost of critical illness insurance is largely dependent on the coverage amount, as well as your health, age, gender, nicotine use and how you get coverage, such as through an employer or an individual plan you buy yourself.

For instance, a 30-year-old nonsmoker may be eligible for an employer-sponsored critical illness insurance policy for $1.64 per month for every $5,000 of coverage from Protective. That would mean you would pay about $8 a month for $25,000 worth of coverage. That same $25,000 policy may cost you $12 per month for a 40-year-old and $19 for a 50-year-old.

In most cases, you can expect to pay lower rates for an individual critical illness insurance if you are young and healthy, with no pre-existing conditions.

Alternatives to Critical Illness Insurance

If you're not sure that critical illness insurance is right for you, alternatives can provide financial protection after a medical diagnosis.

Here are some other secondary health insurance policies you might consider:

- **Disability insurance:** If you become disabled and can't work, disability insurance provides income replacement during that period. Insurers may sell short-term disability insurance and long-term disability insurance, which offer benefits for varying lengths of time.
- **Hospital indemnity insurance:** Hospital indemnity insurance provides monetary benefits if you're hospitalized beyond your health insurance plan. Depending on the policy, hospital indemnity insurance may provide a fixed benefit for an entire hospital stay or it might provide coverage for each day you stay in the hospital.
- **Accident insurance:** Accident insurance provides a lump sum payout if you sustain injuries in an accident, such as a broken bone or severe burn. The money can be used for medical or non-medical expenses.
- **Flexible Spending Account (FSA):** A flexible spending account is essentially a savings account that can be used to cover out-of-pocket healthcare expenses, including copayments and coinsurance. FSAs are also beneficial because you don't pay taxes on the contributions. One drawback with an FSA is that you generally can't carry over funds to the next year unless the employer allows it.
- **Health savings account (HSA):** An HSA is another way to save money to pay for future health care costs, but those savings accounts are connected only to high-deductible health plans (HDHPs). Unlike FSAs, an HSA also lets you carry funds over into the next year and you can take it with you when you change jobs.

What Does Insuring Clause Mean?

The insuring clause is an integral part of any insurance contract and one that all insureds should pay close attention to. The insuring clause is the section of an insurance policy that outlines the risks assumed by the insurer. In other words, this clause details exactly the risks the insurer is liable for paying and defines the scope of the coverage.

Although it is called an insuring clause, it is actually more likely a collection of clauses for all the different perils, losses, and additional coverage an insurer is offering you in the insurance policy. For example, on a typical home insurance policy, your insurance clauses might state that you have coverage for:

- Dwelling Building.
- Detached Private Structures.
- Personal Property.
- 3rd Party Liability.
- Defense Costs & the Right and Duty of the Insurer (to defend you from liability claims)

When you receive a copy of your policy wordings from your insurance company, you should make sure you understand the insuring clause(s) to grasp what is and is not covered by your policy and for how much.

If you have questions about any of the terms contained within, you should contact your insurance provider for clarification. The last thing you want is to find out you do not have coverage for something when you have a claim because by then, it is too late.

Insuranceopedia Explains Insuring Clause

The insuring clause(s) are one of the most critical components of an insurance contract and forms its foundation. It outlines the major guarantees and protections offered by the insurance company and states what is covered. That is why it is so critical for you to understand this part of the policy and to communicate with your insurance provider for clarity if there are any areas you are unsure about.

Put another way, this clause outlines the role the insurance company has agreed to perform as part of the contract. Examples include paying for certain losses arising from insured risks, providing certain agreed-upon services, providing defense for a lawsuit subject to certain conditions, and other agreements that form part of the insurance policy protections you are paying for.

For example, in a life insurance policy, the insuring clause states the main purpose of paying out a specific amount in a death benefit to the named beneficiary after the death of the insured.

In this context, it would include the insurer’s name, the face value payable, and the insured’s name. In more complex policies, the insuring clause(s) section might also include information on the causes of death that are accepted and any limitations (if any) that might apply under different scenarios.

Waiver of Premium in Insurance: Everything You Need to Know

A waiver of premium rider is a life insurance policy provision that eliminates the necessity for premium payments if the policyholder becomes critically ill or disabled. Your health and age may impact your eligibility.

Adding a waiver of premium rider to your life insurance policy protects you against a lapse in coverage if you can’t pay your premiums because of a disability. The definition of disability triggering the waiver of premium benefit varies per insurer, so it’s important to check the fine print.

Depending on the insurance provider, this rider may be included for free as a clause in your policy. However, in most cases, the policyholder will have to add a waiver of premium benefit as a rider at an additional cost.

When adding this provision, note that the waiting period on a waiver of premium rider can also differ among insurers, affecting when the benefit takes effect.

Key Takeaways

A waiver of premium is a type of life insurance policy rider that allows you to waive premium payments should you develop a qualifying disability.

While some companies offer a waiver of premium provision for free as a clause in a life insurance policy, others consider it an add-on that may increase your premiums.

Insurance providers have different qualification requirements, conditions and definitions of disability. Individuals with pre-existing conditions are usually not eligible for a waiver of premium benefit.

Waiver of Premium Benefit in Life Insurance Overview

The waiver of premium provision gets you off the hook for premium payments if you meet certain conditions. For instance, if you become disabled or ill, the insurance company may allow you to stop making premium payments and keep your coverage.

Each company has its own rules for signing up for a waiver of premium rider in life insurance. Generally, the waiver of premium provision is either included in the base policy or must be purchased as a rider.

Getting a waiver of premium as an add-on may make your rates more expensive.

Waiver of Premium in Life Insurance: Mechanisms

The waiver of premium rider can be a vital feature in life insurance policies, providing financial relief during times of disability or severe illness. It allows policyholders to maintain their coverage without financial strain while they are unable to work. Understanding the mechanics of this rider is essential for anyone considering its benefits as part of their life insurance plan.

Activation and Waiting Period

A waiver of premium rider allows an insured to waive premium payments if the insured is fully disabled, as determined by the insurer. However, this rider doesn't activate immediately after a disability or illness is reported. Even after the insurance provider deems you fully disabled, there's typically a waiting period on a waiver of premium rider. During this time, you must continue to pay premiums. If your claim is approved, many insurers will reimburse the premiums paid during this period.

Continuation of Policy Benefits

A life insurance policy waiver of premium rider has the ability to ensure that your policy's benefits continue as if you never missed a payment. If you have whole life or variable life insurance, it will continue to accumulate cash value and dividends, if applicable.

Specifics of Total Disability

The definition of total disability can vary among insurers. Some may define it as the inability to perform your regular job, while others may require that you be unable to perform any job. Understanding this definition is vital when considering the waiver of premium rider.

Choosing a life insurance policy with a waiver of premium rider can significantly impact your financial security during unexpected life events. It's advisable to carefully review the terms associated with this rider and discuss them with your insurance advisor to ensure you fully understand and can take advantage of its provisions.

Waiver of Premium in Life Insurance: Cost

The cost of adding a waiver of premium rider to your life insurance policy can vary widely based on factors like age, occupation, health and the type of policy. For instance, a young, healthy individual working in a low-risk occupation may find the cost of this rider to be relatively minimal. Conversely, someone in a high-risk job or with pre-existing health conditions might face a higher expense.

Although a waiver of premium benefit may seem like an additional expense at the outset, the protection it offers can be invaluable for certain policyholders. For example, a sole breadwinner with a family relying on their income may find this a good addition to their coverage. If an unexpected illness or accident leaves them unable to work, paying life insurance premiums may become a monetary strain. Having a disability waiver of premium rider could be a financial lifeline, ensuring that the life insurance policy continues without the need for premium payments during the period of disability.

EXPERT TIP

When purchasing a life insurance policy, make sure you check the fine print. Not all policies have a waiver of premium clause. Most insurance providers also don’t offer this benefit to anyone over 65. If you’re a senior, you're likely ineligible.

Benefits of a Waiver of Premium Provision

A waiver of premium rider in life insurance can serve as a financial safety net to help you in a time of need. But it may not be a suitable option for everyone. Understanding this provision's unique benefits can help determine if it's right for you.

It offers financial protection

Getting seriously ill or injured can leave you unable to work. A waiver of premium rider will allow you to stop making payments for your life insurance policy. Instead, this rider will cover the premiums.

It prevents a lapse in coverage

An inability to make premium payments can cause your life insurance coverage to lapse. A waiver of premium clause can prevent that from happening as it waives off your future payments until you recover.

It isn't limited to one use

Using a waiver of premium in life insurance isn't limited to one incident. You may use it several times as long as you meet the qualifications. That's especially helpful should your disability or illness recur.

It helps reduce stress

An illness or disability doesn't only affect you physically but also mentally. Worrying about your finances and premium payments can add to your stress. With a waiver of premium benefit, you don't have to figure out how to pay for your policy while recovering.

Potential Drawbacks of a Waiver of Premium Rider

While the waiver of premium rider provides valuable financial protection, it also comes with potential drawbacks. Understanding these can help you make an informed decision that aligns with your unique needs and circumstances.

There's an additional cost

Adding a waiver of premium rider isn't free and can increase the overall cost of your policy. Weigh this against the benefits it offers.

There may be a waiting period

Many policies include a waiting period for a waiver of premium rider. Also referred to as an elimination period, this time depends on the insurance provider. In most cases, it's around six months. This delay can be challenging if you're unable to work during this time.

Qualifications may vary

The definitions for qualifying disabilities or illnesses can vary, and some waiver of premium riders might not cover partial disabilities, limiting the protection.

There may be duration limits

Some riders only waive premiums up to a certain age, such as 60 or 65, potentially leaving you with out-of-pocket expenses afterward.

You may need to undergo medical examinations

Insurance companies may require policyholders with a waiver of premium rider to get periodic medical examinations to continue the benefits.

Factors to Consider When Adding a Waiver of Premium Provision to a Policy

It's wise to consider some factors before adding a waiver of premium provision to your life insurance policy. Get information from your insurance provider because conditions, rules and requirements vary per insurer. Reading the fine print can help you better understand how this benefit works.

Factor	Description
Qualifications	Eligibility requirements for a waiver of premium rider vary depending on the insurance carrier, so clarify them with the provider early on. Typically, the policyholder must be less than 60 or 65 years old. They shouldn't have a pre-existing disability or illness. The insurer may also consider overall health, lifestyle and occupation. Some provisions may only activate if the disability keeps you from working for a minimum of six months.
Waiting period	In most cases, the waiver of premium for disability only takes effect after the waiting period passes. This can be anywhere from a few months to a year, usually six months.
Duration	The waiver of premium provision takes effect after the waiting period and lasts until the policyholder recovers from the disability. In some cases, the duration may be up to a specific age. The policy contract will have the details. After the duration of the waiver, the policyholder will have to pay premiums again.
Expiration date	The waiver of premium in life insurance may expire depending on the terms and conditions stated in the policy contract. Usually, the age limit is 60 or 65. After this age, the policyholder will likely no longer qualify for the premium waiver.
Cost	Adding riders, such as a waiver of premium, may add additional cost to your life insurance rate. The amount depends on the insurer and individualized factors like your age and health. This is typically up to 25% of your policy's cost.

INTERPRETATIONS OF QUALIFYING DISABILITIES

A waiver of premium rider takes effect when the policyholder suffers from a disability. However, not all types of disabilities may qualify, and insurance companies interpret disability in various ways.

Here are some common interpretations of what can be considered a qualifying disability:

- An injury or sickness caused the disability.
- The disability causes loss of mobility, such as losing a limb.
- The disability causes sensory loss, such as hearing impairment or blindness.
- An injury or illness prevents the policyholder from performing the occupation they qualified for through education, experience or training.

Reasons to Add a Waiver of Premium Rider to a Life Insurance Policy

Although a waiver of premium rider offers multiple benefits, it's not always the best option. It can be suitable for people with only one source of income, who have high-risk professions or hobbies or who have a family history of serious illness.

You only have one source of income

A disability can prevent you from going to work, which means you may suffer from a temporary loss of income. If you only have one source of income, getting a waiver of premium rider may be wise since it lessens the possible financial burdens you may have to face if you become disabled.

You have a high-risk profession

Some jobs come with inherent risks. If there's a high chance of you getting injured on the job, consider looking for a policy with a waiver of premium provision.

Examples of high-risk professions include the following:

- Firefighters
- Police officers
- Pilots
- Construction workers
- Moving company employees
- Bus and truck drivers
- EMTs
- Nurses

You have risky hobbies

Certain hobbies and activities may increase the risk of serious injuries leading to disability. A waiver of premium benefit provides a financial safety net should unexpected incidents happen.

You're at risk of getting a serious illness based on your family history

If you think you're at risk of getting a disease based on your family health history, getting a waiver of premium benefit may be a smart move. It can be a form of preparation for unfortunate circumstances should you also suffer from a similar condition and end up with a disability.

EXPERT TIP

The Centers for Disease Control and Prevention (CDC) reported that around 27% of Americans have some type of disability. While life can be unpredictable, and there's no sure way of knowing whether a person will eventually have a disability, certain lifestyles may increase the risk. If you know you have specific risk factors, it might be worth getting a waiver of premium.

How to File a Waiver of Premium Claim

If you're interested in getting a waiver of premium clause, you should add it to your policy when you buy your life insurance. The following steps will walk you through the process of filing a waiver of premium claim if you have a covered disability.

Get a medical statement from your doctor

Requirements for filing a waiver of premium claim depend on the insurance provider. Typically, it includes submitting a medical statement from a doctor — you can't say that you have a disability without proof.

Your insurance provider will then determine if you're qualified for a claim. Make sure the certificate provides details on your condition and that it prevents you from working.

Obtain a notice from the Social Security Administration (SSA)

In some instances, the insurance provider may require additional evidence by requesting a copy of a notice from the SSA. This document can confirm a disability or physical impairment. It will also verify your inability to work due to your disability.

You can find the nearest SSA office using the agency's field office locator.

Contact your insurer and file your claim

Let your insurance provider know about your plan to file a claim. Ask them if there are any additional requirements. They may ask you to fill out a claim form or provide additional information.

Depending on the company, you may be able to file a claim online or through mail or fax.

Navigating the process of filing a waiver of premium claim requires attention to detail and adherence to your insurer's specific procedures. By following these steps and ensuring all documentation is complete and accurate, you can facilitate the approval of your claim, allowing you to focus on your health without the financial burden of premium payments.

FAQ About Waiver of Premium in Insurance

What is an insurance waiver?

An insurance waiver is a document or provision that allows an individual to opt out of required insurance coverage or exempts them from certain conditions within an insurance policy.

What is a waiver of premium rider in life insurance?

A waiver of premium can be a clause or rider that allows the policyholder to waive their premium payments in the event of a qualifying disability or illness.

What is a disability waiver?

A disability waiver, also known as a disability waiver of premium rider, is a specific type of waiver of premium. Generally, the term "waiver of premium" broadly applies to any condition under which the insurance company allows the cessation of premium payments while the coverage continues. The "disability waiver of premium rider" specifically refers to the condition being related to the policyholder's disability.

What is the level of disability required to activate a waiver of premium provision?

The definition of a qualifying disability differs per insurer. We recommend checking with the insurance company to find out more.

What is the waiting period for a waiver of premium rider in life insurance policies?

Typically, the waiver of premium rider waiting period spans around six months, but it can vary from a few months to a year, depending on the insurer's policy.

How do you file a waiver of premium claim?

The claims process for a waiver of premium benefit may vary per insurer. Typically, it includes submitting a medical statement from a doctor, an SSA notice and a completed claim form.

Which type of life insurance rider will waive the premium?

A waiver of premium rider or a disability waiver of premium rider is designed to waive premium payments on a life insurance policy in the event of a qualifying disability.

When does a life insurance policy waiver of premium take effect?

A waiver of premium in life insurance generally takes effect after the specified waiting period, provided the policyholder meets the criteria for a qualifying disability as defined by the insurer.

What is a payor benefit rider?

A payor benefit clause or rider, also known as a juvenile waiver rider, is an addition to a life insurance policy that waives premium payments if the policy's payor, typically a parent or guardian, passes away or becomes disabled. This ensures the policy remains active for the beneficiary.

Which provision does the waiver of premium not include?

Life insurance waiver of premium does not include coverage for short-term disabilities or illnesses that do not meet the insurer's definition of total disability, as specified in the policy's terms.

What are life insurance exclusions?

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As you get older, having a life insurance policy in place may allow you to leave money to your loved ones if you pass away. However, not everyone knows that there are certain exclusions that might prevent your beneficiaries from claiming your death benefit. If you have a life insurance policy, it's important to know what those exclusions are so your loved ones can avoid any surprises following your death.

Common life insurance policy exclusions

A life insurance exclusion is a situation or circumstance that prevents your beneficiaries from receiving your death benefit. Essentially, it means that certain causes of death are not covered by the policy. Life insurance exclusions are regulated at the state level, but insurance companies can decide which of those exclusions they include in their policies. Exclusions will be listed in the policy at the time of application, so the insured will know which causes of death may not be covered by the policy before accepting a policy.

The main reason life insurance companies add exclusions is to protect them from risk — namely untimely deaths, which may cost the company more money in the form of an early death benefit. Exclusions are a way for insurers to reduce the likelihood of paying a death benefit in certain situations.

You might be surprised to learn what situations may not be covered by insurance. Some common life insurance exclusions include death caused by:

- **Suicide:** If the policyholder dies by suicide within a certain timeframe after purchasing their policy, then a life insurance suicide exclusion likely applies, and the insured's beneficiaries are not eligible for death benefits. In most cases, the suicide clause is a two-year period, but this will be defined in the policy.
- **Acts of war:** If a policyholder dies as a result of wartime activities, coverage may be denied.
- **Service in the military:** Because military service may make a policyholder a higher risk to insure, this exclusion may be present in policies.
- **Aviation accident:** Although fairly rare anymore, death caused by aviation accidents is a common life insurance exclusion.

James Miles, consulting staff fellow for the Society of Actuaries, says virtually every life insurer typically includes the same outright exclusion in its policy: a suicide clause.

"Depending on the state, it's usually a two-year suicide clause. If you die by suicide within the first two years of the contract, the beneficiary would receive the premiums back but not the death benefit," he says.

The suicide clause is in place to prevent individuals from purchasing a life insurance policy when they are struggling with mental health disorders or are planning suicide.

Most life insurance companies screen applicants for mental health conditions, like depression and anxiety, before they are approved for coverage. And while you will likely pay a higher premium if you are living with a mental health condition, you will still most likely be able to get a life insurance policy.

In the case of physician-assisted suicide, the same rule applies. If you live in a state where assisted suicide is legal, you must pass the two-year period before you can claim death benefits.

Accidental death policy exclusions

Some life insurance policies, known as accidental death policies, only provide coverage for the insured if they die due to an accident. Causes of death related to illness, medical issues or chronic health conditions are not covered. These policies will define what constitutes an accident and may include exclusions due to death from:

- **Illegal activity:** When someone dies as a result of illegal activity, their beneficiaries likely cannot claim their death benefits. This includes everything from drug deals gone wrong to DUI crashes.
- **Risky activity:** Any death due to risky activities, such as skydiving or rock climbing, are usually counted as an exclusion.
- **Substance abuse:** If a policyholder's death is the result of drug or alcohol abuse, it may be excluded from their policy.

It's also worth noting that risky hobbies, substance abuse and misrepresentation (providing false information on your application) could bar you from getting coverage in the first place or subject you to a higher premium.

Additionally, life insurance policies have a contestability period, in which life insurance companies can investigate your application and deny claims. This period is typically one to two years from the effective date of the policy. If you pass during the contestability period and the insurer determines you misrepresented yourself, or provided any false information to your life insurance company, it could completely void your coverage and no death benefits will be paid.

How do I know if I have life insurance exclusions on my policy?

Knowing what your life insurance covers may be vital. After all, some types of life insurance will cover you for your entire life — which means making premium payments for your entire life, too. As such, not understanding your life insurance exclusions could prove to be a costly mistake.

One way to learn more about the exclusions on your life insurance policy is to read through your contract. Although it may be dense, your contract will spell out precisely what is and isn't covered on your life insurance policy. However, life insurance is complex, and contracts may be hard to decipher. With that in mind, it may be a good idea to meet with your life insurance agent, so they can break it down for you.

Do life insurance exclusions change over time?

Over the years, life insurance companies have altered their definition of risky behavior based on global, economic and socially-driven changes. For instance, some life

insurance companies used to exclude private aviation from the list of covered causes of death. However, as private aircraft became safer, many life insurance companies eased up on the rules for most policyholders. Today, some life insurance companies offer an aviation rider for recreational pilots.

It's important to note that although some circumstances and health statuses may not be exclusions on your life insurance policy, they could be risk factors that may contribute to a higher premium. Additionally, every insurance company is different, so it's important to read through your contract to understand your policy limitations.

Summary of the HIPAA Privacy Rule

This is a summary of key elements of the Privacy Rule including who is covered, what information is protected, and how protected health information can be used and disclosed. Because it is an overview of the Privacy Rule, it does not address every detail of each provision.

Summary of the Privacy Rule - PDF

Introduction

- The *Standards for Privacy of Individually Identifiable Health Information* ("Privacy Rule") establishes, for the first time, a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services ("HHS") issued the Privacy Rule to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").[1] The Privacy Rule standards address the use and disclosure of individuals' health information—called "protected health information" by organizations subject to the Privacy Rule — called "covered entities," as well as standards for individuals' privacy rights to understand and control how their health information is used. Within HHS, the Office for Civil Rights ("OCR") has responsibility for implementing and enforcing the Privacy Rule with respect to voluntary compliance activities and civil money penalties.

A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well being. The Rule strikes a balance that permits important uses of information, while protecting the privacy of people who seek care and healing. Given that the health care marketplace is diverse, the Rule is designed to be flexible and comprehensive to cover the variety of uses and disclosures that need to be addressed.

This is a summary of key elements of the Privacy Rule and not a complete or comprehensive guide to compliance. Entities regulated by the Rule are obligated to comply with all of its applicable requirements and should not rely on this summary as a source of legal information or advice. To make it easier for entities to review the complete requirements of the Rule, provisions of the Rule referenced in this summary are cited in the end notes. Visit our Privacy Rule section to view the entire Rule, and for other additional helpful information about how the Rule applies. In the event of a conflict between this summary and the Rule, the Rule governs.

Statutory and Regulatory Background

- The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of HHS to publicize standards for the electronic exchange, privacy and security of health information. Collectively these are known as the *Administrative Simplification* provisions.

HIPAA required the Secretary to issue privacy regulations governing individually identifiable health information, if Congress did not enact privacy legislation within three years of the passage of HIPAA. Because Congress did not enact privacy legislation, HHS developed a proposed rule and released it for public comment on November 3, 1999. The Department received over 52,000 public comments. The final regulation, the Privacy Rule, was published December 28, 2000.[2]

In March 2002, the Department proposed and released for public comment modifications to the Privacy Rule. The Department received over 11,000 comments.The final modifications were published in final form on August 14, 2002.[3] A text combining the final regulation and the modifications can be found at 45 CFR Part 160 and Part 164, Subparts A and E.

Who is Covered by the Privacy Rule

The Privacy Rule, as well as all the Administrative Simplification rules, apply to health plans, health care clearinghouses, and to any health care provider who transmits health information in electronic form in connection with transactions for which the Secretary of HHS has adopted standards under HIPAA (the "covered entities"). For help in determining whether you are covered, use CMS's decision tool.

Health Plans. Individual and group plans that provide or pay the cost of medical care are covered entities.[4] Health plans include health, dental, vision, and prescription drug insurers, health maintenance organizations ("HMOs"), Medicare, Medicaid, Medicare+Choice and Medicare supplement insurers, and long-term care insurers (excluding nursing home fixed-indemnity policies). Health plans also include employer-sponsored group health plans, government and church-sponsored health plans, and multi-employer health plans. There are exceptions—a group health plan with less than 50 participants that is administered solely by the employer that established and maintains the plan is not a covered entity. Two types of government-funded programs are not health plans: (1) those whose principal purpose is not providing or paying the cost of health care, such as the food stamps program; and (2) those programs whose principal activity is directly providing health care, such as a community health center,[5] or the making of grants to fund the direct provision of health care. Certain types of insurance entities are also not health plans, including entities providing only workers' compensation, automobile insurance, and property and casualty insurance. If an insurance entity has separable lines of business, one of which is a health plan, the HIPAA regulations apply to the entity with respect to the health plan line of business.

Health Care Providers. Every health care provider, regardless of size, who electronically transmits health information in connection with certain transactions, is a covered entity. These transactions include claims, benefit eligibility inquiries, referral authorization requests, or other transactions for which HHS has established standards under the HIPAA Transactions Rule.[6] Using electronic technology, such as email, does not mean a health care provider is a covered entity; the transmission must be in connection with a standard transaction. The Privacy Rule covers a health care provider whether it electronically transmits these transactions directly or uses a billing service or other third party to do so on its behalf. Health care providers include all "providers of services" (e.g., institutional providers such as hospitals) and "providers of medical or health services" (e.g., non-institutional providers such as physicians, dentists and other practitioners) as defined by Medicare, and any other person or organization that furnishes, bills, or is paid for health care.

Health Care Clearinghouses. *Health care clearinghouses* are entities that process nonstandard information they receive from another entity into a standard (i.e., standard format or data content), or vice versa.[7] In most instances, health care clearinghouses will receive individually identifiable health information only when they are providing these processing services to a health plan or health care provider as a business associate. In such instances, only certain provisions of the Privacy Rule are applicable to the health care clearinghouse's uses and disclosures of protected health information.[8] Health care clearinghouses include billing services, repricing companies, community health management information systems, and value-added networks and switches if these entities perform clearinghouse functions.

Business Associates

Business Associate Defined. In general, a business associate is a person or organization, other than a member of a covered entity's workforce, that performs certain functions or activities on behalf of, or provides certain services to, a covered entity that involve the use or disclosure of individually identifiable health information. Business associate functions or activities on behalf of a covered entity include claims processing, data analysis, utilization review, and billing.[9] Business associate services to a covered entity are limited to legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services. However, persons or organizations are not considered business associates if their functions or services do not involve the use or disclosure of protected health information, and where any access to protected health information by such persons would be incidental, if at all. A covered entity can be the business associate of another covered entity.

Business Associate Contract. When a covered entity uses a contractor or other non-workforce member to perform *"business associate"* services or activities, the Rule requires that the covered entity include certain protections for the information in a business associate agreement (in certain circumstances governmental entities may use alternative means to achieve the same protections). In the business associate contract, a covered entity must impose specified written safeguards on the individually identifiable health information used or disclosed by its business associates.[10] Moreover, a covered entity may not contractually authorize its business associate to make any use or disclosure of protected health information that would violate the Rule. Covered entities

that had an existing written contract or agreement with business associates prior to October 15, 2002, which was not renewed or modified prior to April 14, 2003, were permitted to continue to operate under that contract until they renewed the contract or April 14, 2004, whichever was first.[11] See additional guidance on Business Associates and sample business associate contract language.

What Information is Protected

Protected Health Information. The Privacy Rule protects all *"individually identifiable health information"* held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information "protected health information (PHI)."[12]

"Individually identifiable health information" is information, including demographic data, that relates to:

- the individual's past, present or future physical or mental health or condition,
- the provision of health care to the individual, or
- the past, present, or future payment for the provision of health care to the individual,

and that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual.[13] Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).

The Privacy Rule excludes from protected health information employment records that a covered entity maintains in its capacity as an employer and education and certain other records subject to, or defined in, the Family Educational Rights and Privacy Act, 20 U.S.C. §1232g.

De-Identified Health Information. There are no restrictions on the use or disclosure of de-identified health information.[14] De-identified health information neither identifies nor provides a reasonable basis to identify an individual. There are two ways to de-identify information; either: (1) a formal determination by a qualified statistician; or (2) the removal of specified identifiers of the individual and of the individual's relatives, household members, and employers is required, and is adequate only if the covered entity has no actual knowledge that the remaining information could be used to identify the individual.[15]

General Principle for Uses and Disclosures

Basic Principle. A major purpose of the Privacy Rule is to define and limit the circumstances in which an individual's protected heath information may be used or disclosed by covered entities. A covered entity may not use or disclose protected health information, except either: (1) as the Privacy Rule permits or requires; or (2) as the individual who is the subject of the information (or the individual's personal representative) authorizes in writing.[16]

Required Disclosures. A covered entity must disclose protected health information in only two situations: (a) to individuals (or their personal representatives) specifically when they request access to, or an accounting of disclosures of, their protected health

information; and (b) to HHS when it is undertaking a compliance investigation or review or enforcement action.[17] See additional guidance on Government Access.

Permitted Uses and Disclosures

Permitted Uses and Disclosures. A covered entity is permitted, but not required, to use and disclose protected health information, without an individual's authorization, for the following purposes or situations: (1) To the Individual (unless required for access or accounting of disclosures); (2) Treatment, Payment, and Health Care Operations; (3) Opportunity to Agree or Object; (4) Incident to an otherwise permitted use and disclosure; (5) Public Interest and Benefit Activities; and (6) Limited Data Set for the purposes of research, public health or health care operations.[18] Covered entities may rely on professional ethics and best judgments in deciding which of these permissive uses and disclosures to make.

(1) To the Individual. A covered entity may disclose protected health information to the individual who is the subject of the information.

(2) Treatment, Payment, Health Care Operations. A covered entity may use and disclose protected health information for its own treatment, payment, and health care operations activities.[19] A covered entity also may disclose protected health information for the treatment activities of any health care provider, the payment activities of another covered entity and of any health care provider, or the health care operations of another covered entity involving either quality or competency assurance activities or fraud and abuse detection and compliance activities, if both covered entities have or had a relationship with the individual and the protected health information pertains to the relationship. See additional guidance on Treatment, Payment, & Health Care Operations.

Treatment is the provision, coordination, or management of health care and related services for an individual by one or more health care providers, including consultation between providers regarding a patient and referral of a patient by one provider to another.[20]

Payment encompasses activities of a health plan to obtain premiums, determine or fulfill responsibilities for coverage and provision of benefits, and furnish or obtain reimbursement for health care delivered to an individual[21] and activities of a health care provider to obtain payment or be reimbursed for the provision of health care to an individual.

Health care operations are any of the following activities: (a) quality assessment and improvement activities, including case management and care coordination; (b) competency assurance activities, including provider or health plan performance evaluation, credentialing, and accreditation; (c) conducting or arranging for medical reviews, audits, or legal services, including fraud and abuse detection and compliance programs; (d) specified insurance functions, such as underwriting, risk rating, and reinsuring risk; (e) business planning, development, management, and administration; and (f) business management and general administrative activities of the entity, including but not limited to: de-identifying protected health information, creating a limited data set, and certain fundraising for the benefit of the covered entity.[22]

Most uses and disclosures of psychotherapy notes for treatment, payment, and health care operations purposes require an authorization as described below.[23] Obtaining "consent" (written permission from individuals to use and disclose their protected health information for treatment, payment, and health care operations) is optional under the Privacy Rule for all covered entities.[24] The content of a consent form, and the process for obtaining consent, are at the discretion of the covered entity electing to seek consent.

(3) Uses and Disclosures with Opportunity to Agree or Object. Informal permission may be obtained by asking the individual outright, or by circumstances that clearly give the individual the opportunity to agree, acquiesce, or object. Where the individual is incapacitated, in an emergency situation, or not available, covered entities generally may make such uses and disclosures, if in the exercise of their professional judgment, the use or disclosure is determined to be in the best interests of the individual.

Facility Directories. It is a common practice in many health care facilities, such as hospitals, to maintain a directory of patient contact information. A covered health care provider may rely on an individual's informal permission to list in its facility directory the individual's name, general condition, religious affiliation, and location in the provider's facility.[25] The provider may then disclose the individual's condition and location in the facility to anyone asking for the individual by name, and also may disclose religious affiliation to clergy. Members of the clergy are not required to ask for the individual by name when inquiring about patient religious affiliation.

For Notification and Other Purposes. A covered entity also may rely on an individual's informal permission to disclose to the individual's family, relatives, or friends, or to other persons whom the individual identifies, protected health information directly relevant to that person's involvement in the individual's care or payment for care.[26] This provision, for example, allows a pharmacist to dispense filled prescriptions to a person acting on behalf of the patient. Similarly, a covered entity may rely on an individual's informal permission to use or disclose protected health information for the purpose of notifying (including identifying or locating) family members, personal representatives, or others responsible for the individual's care of the individual's location, general condition, or death. In addition, protected health information may be disclosed for notification purposes to public or private entities authorized by law or charter to assist in disaster relief efforts.

(4) Incidental Use and Disclosure. The Privacy Rule does not require that every risk of an incidental use or disclosure of protected health information be eliminated. A use or disclosure of this information that occurs as a result of, or as "incident to," an otherwise permitted use or disclosure is permitted as long as the covered entity has adopted reasonable safeguards as required by the Privacy Rule, and the information being shared was limited to the "minimum necessary," as required by the Privacy Rule.[27] See additional guidance on Incidental Uses and Disclosures.

(5) Public Interest and Benefit Activities. The Privacy Rule permits use and disclosure of protected health information, without an individual's authorization or permission, for 12 national priority purposes.[28] These disclosures are permitted, although not required, by the Rule in recognition of the important uses made of health

information outside of the health care context. Specific conditions or limitations apply to each public interest purpose, striking the balance between the individual privacy interest and the public interest need for this information.

Required by Law. Covered entities may use and disclose protected health information without individual authorization as required by law (including by statute, regulation, or court orders).[29]

Public Health Activities. Covered entities may disclose protected health information to: (1) public health authorities authorized by law to collect or receive such information for preventing or controlling disease, injury, or disability and to public health or other government authorities authorized to receive reports of child abuse and neglect; (2) entities subject to FDA regulation regarding FDA regulated products or activities for purposes such as adverse event reporting, tracking of products, product recalls, and post-marketing surveillance; (3) individuals who may have contracted or been exposed to a communicable disease when notification is authorized by law; and (4) employers, regarding employees, when requested by employers, for information concerning a work-related illness or injury or workplace related medical surveillance, because such information is needed by the employer to comply with the Occupational Safety and Health Administration (OHSA), the Mine Safety and Health Administration (MHSA), or similar state law.[30] See additional guidance on Public Health Activities and CDC's web pages on Public Health and HIPAA Guidance.

Victims of Abuse, Neglect or Domestic Violence. In certain circumstances, covered entities may disclose protected health information to appropriate government authorities regarding victims of abuse, neglect, or domestic violence.[31]

Health Oversight Activities. Covered entities may disclose protected health information to health oversight agencies (as defined in the Rule) for purposes of legally authorized health oversight activities, such as audits and investigations necessary for oversight of the health care system and government benefit programs.[32]

Judicial and Administrative Proceedings. Covered entities may disclose protected health information in a judicial or administrative proceeding if the request for the information is through an order from a court or administrative tribunal. Such information may also be disclosed in response to a subpoena or other lawful process if certain assurances regarding notice to the individual or a protective order are provided.[33]

Law Enforcement Purposes. Covered entities may disclose protected health information to law enforcement officials for law enforcement purposes under the following six circumstances, and subject to specified conditions: (1) as required by law (including court orders, court-ordered warrants, subpoenas) and administrative requests; (2) to identify or locate a suspect, fugitive, material witness, or missing person; (3) in response to a law enforcement official's request for information about a victim or suspected victim of a crime; (4) to alert law enforcement of a person's death, if the covered entity suspects that criminal activity caused the death; (5) when a covered entity believes that protected health information is evidence of a crime that occurred on its premises; and (6) by a covered health care provider in a medical emergency not occurring on its premises, when necessary to inform law enforcement about the

commission and nature of a crime, the location of the crime or crime victims, and the perpetrator of the crime.[34]

Decedents. Covered entities may disclose protected health information to funeral directors as needed, and to coroners or medical examiners to identify a deceased person, determine the cause of death, and perform other functions authorized by law.[35]

Cadaveric Organ, Eye, or Tissue Donation. Covered entities may use or disclose protected health information to facilitate the donation and transplantation of cadaveric organs, eyes, and tissue.[36]

Research. "Research" is any systematic investigation designed to develop or contribute to generalizable knowledge.[37] The Privacy Rule permits a covered entity to use and disclose protected health information for research purposes, without an individual's authorization, provided the covered entity obtains either: (1) documentation that an alteration or waiver of individuals' authorization for the use or disclosure of protected health information about them for research purposes has been approved by an Institutional Review Board or Privacy Board; (2) representations from the researcher that the use or disclosure of the protected health information is solely to prepare a research protocol or for similar purpose preparatory to research, that the researcher will not remove any protected health information from the covered entity, and that protected health information for which access is sought is necessary for the research; or (3) representations from the researcher that the use or disclosure sought is solely for research on the protected health information of decedents, that the protected health information sought is necessary for the research, and, at the request of the covered entity, documentation of the death of the individuals about whom information is sought.[38] A covered entity also may use or disclose, without an individuals' authorization, a limited data set of protected health information for research purposes (see discussion below).[39] See additional guidance on Research and NIH's publication of "Protecting Personal Health Information in Research: Understanding the HIPAA Privacy Rule." - PDF

Serious Threat to Health or Safety. Covered entities may disclose protected health information that they believe is necessary to prevent or lessen a serious and imminent threat to a person or the public, when such disclosure is made to someone they believe can prevent or lessen the threat (including the target of the threat). Covered entities may also disclose to law enforcement if the information is needed to identify or apprehend an escapee or violent criminal.[40]

Essential Government Functions. An authorization is not required to use or disclose protected health information for certain essential government functions. Such functions include: assuring proper execution of a military mission, conducting intelligence and national security activities that are authorized by law, providing protective services to the President, making medical suitability determinations for U.S. State Department employees, protecting the health and safety of inmates or employees in a correctional institution, and determining eligibility for or conducting enrollment in certain government benefit programs.[41]

Workers' Compensation. Covered entities may disclose protected health information as authorized by, and to comply with, workers' compensation laws and other similar

programs providing benefits for work-related injuries or illnesses.[42] See additional guidance on Workers' Compensation.

(6) Limited Data Set. A limited data set is protected health information from which certain specified direct identifiers of individuals and their relatives, household members, and employers have been removed.43 A limited data set may be used and disclosed for research, health care operations, and public health purposes, provided the recipient enters into a data use agreement promising specified safeguards for the protected health information within the limited data set.

Authorized Uses and Disclosures

Authorization. A covered entity must obtain the individual's written authorization for any use or disclosure of protected health information that is not for treatment, payment or health care operations or otherwise permitted or required by the Privacy Rule.[44] A covered entity may not condition treatment, payment, enrollment, or benefits eligibility on an individual granting an authorization, except in limited circumstances.[45]

An authorization must be written in specific terms. It may allow use and disclosure of protected health information by the covered entity seeking the authorization, or by a third party. Examples of disclosures that would require an individual's authorization include disclosures to a life insurer for coverage purposes, disclosures to an employer of the results of a pre-employment physical or lab test, or disclosures to a pharmaceutical firm for their own marketing purposes.

All authorizations must be in plain language, and contain specific information regarding the information to be disclosed or used, the person(s) disclosing and receiving the information, expiration, right to revoke in writing, and other data. The Privacy Rule contains transition provisions applicable to authorizations and other express legal permissions obtained prior to April 14, 2003.[46]

Psychotherapy Notes.[47] A covered entity must obtain an individual's authorization to use or disclose psychotherapy notes with the following exceptions:[48]

- The covered entity who originated the notes may use them for treatment.
- A covered entity may use or disclose, without an individual's authorization, the psychotherapy notes, for its own training, and to defend itself in legal proceedings brought by the individual, for HHS to investigate or determine the covered entity's compliance with the Privacy Rules, to avert a serious and imminent threat to public health or safety, to a health oversight agency for lawful oversight of the originator of the psychotherapy notes, for the lawful activities of a coroner or medical examiner or as required by law.

Marketing. Marketing is any communication about a product or service that encourages recipients to purchase or use the product or service.[49] The Privacy Rule carves out the following health-related activities from this definition of marketing:

- Communications to describe health-related products or services, or payment for them, provided by or included in a benefit plan of the covered entity making the communication;

- Communications about participating providers in a provider or health plan network, replacement of or enhancements to a health plan, and health-related products or services available only to a health plan's enrollees that add value to, but are not part of, the benefits plan;
- Communications for treatment of the individual; and
- Communications for case management or care coordination for the individual, or to direct or recommend alternative treatments, therapies, health care providers, or care settings to the individual.

Marketing also is an arrangement between a covered entity and any other entity whereby the covered entity discloses protected health information, in exchange for direct or indirect remuneration, for the other entity to communicate about its own products or services encouraging the use or purchase of those products or services. A covered entity must obtain an authorization to use or disclose protected health information for marketing, except for face-to-face marketing communications between a covered entity and an individual, and for a covered entity's provision of promotional gifts of nominal value. No authorization is needed, however, to make a communication that falls within one of the exceptions to the marketing definition. An authorization for marketing that involves the covered entity's receipt of direct or indirect remuneration from a third party must reveal that fact. See additional guidance on Marketing.

Limiting Uses and Disclosures to the Minimum Necessary

Minimum Necessary. A central aspect of the Privacy Rule is the principle of "minimum necessary" use and disclosure. A covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request.[50] A covered entity must develop and implement policies and procedures to reasonably limit uses and disclosures to the minimum necessary. When the minimum necessary standard applies to a use or disclosure, a covered entity may not use, disclose, or request the entire medical record for a particular purpose, unless it can specifically justify the whole record as the amount reasonably needed for the purpose. See additional guidance on Minimum Necessary.

The minimum necessary requirement is not imposed in any of the following circumstances: (a) disclosure to or a request by a health care provider for treatment; (b) disclosure to an individual who is the subject of the information, or the individual's personal representative; (c) use or disclosure made pursuant to an authorization; (d) disclosure to HHS for complaint investigation, compliance review or enforcement; (e) use or disclosure that is required by law; or (f) use or disclosure required for compliance with the HIPAA Transactions Rule or other HIPAA Administrative Simplification Rules.

Access and Uses. For internal uses, a covered entity must develop and implement policies and procedures that restrict access and uses of protected health information based on the specific roles of the members of their workforce. These policies and procedures must identify the persons, or classes of persons, in the workforce who need access to protected health information to carry out their duties, the categories of

protected health information to which access is needed, and any conditions under which they need the information to do their jobs.

Disclosures and Requests for Disclosures. Covered entities must establish and implement policies and procedures (which may be standard protocols) for *routine, recurring disclosures, or requests for disclosures*, that limits the protected health information disclosed to that which is the minimum amount reasonably necessary to achieve the purpose of the disclosure. Individual review of each disclosure is not required. For non-routine, non-recurring disclosures, or requests for disclosures that it makes, covered entities must develop criteria designed to limit disclosures to the information reasonably necessary to accomplish the purpose of the disclosure and review each of these requests individually in accordance with the established criteria.

Reasonable Reliance. If another covered entity makes a request for protected health information, a covered entity may rely, if reasonable under the circumstances, on the request as complying with this minimum necessary standard. Similarly, a covered entity may rely upon requests as being the minimum necessary protected health information from: (a) a public official, (b) a professional (such as an attorney or accountant) who is the covered entity's business associate, seeking the information to provide services to or for the covered entity; or (c) a researcher who provides the documentation or representation required by the Privacy Rule for research.

Notice and Other Individual Rights

Privacy Practices Notice. Each covered entity, with certain exceptions, must provide a notice of its privacy practices.[51] The Privacy Rule requires that the notice contain certain elements. The notice must describe the ways in which the covered entity may use and disclose protected health information. The notice must state the covered entity's duties to protect privacy, provide a notice of privacy practices, and abide by the terms of the current notice. The notice must describe individuals' rights, including the right to complain to HHS and to the covered entity if they believe their privacy rights have been violated. The notice must include a point of contact for further information and for making complaints to the covered entity. Covered entities must act in accordance with their notices. The Rule also contains specific distribution requirements for direct treatment providers, all other health care providers, and health plans. See additional guidance on Notice.

- **Notice Distribution.** A covered health care provider with a *direct treatment* relationship with individuals must have delivered a privacy practices notice to patients starting April 14, 2003 as follows:

- Not later than the first service encounter by personal delivery (for patient visits), by automatic and contemporaneous electronic response (for electronic service delivery), and by prompt mailing (for telephonic service delivery);

- By posting the notice at each service delivery site in a clear and prominent place where people seeking service may reasonably be expected to be able to read the notice; and

- In emergency treatment situations, the provider must furnish its notice as soon as practicable after the emergency abates.

Covered entities, whether direct treatment providers or indirect treatment providers (such as laboratories) or health plans must supply notice to anyone on request.[52] A covered entity must also make its notice electronically available on any web site it maintains for customer service or benefits information.

The covered entities in an organized health care arrangement may use a joint privacy practices notice, as long as each agrees to abide by the notice content with respect to the protected health information created or received in connection with participation in the arrangement.[53] Distribution of a joint notice by any covered entity participating in the organized health care arrangement at the first point that an OHCA member has an obligation to provide notice satisfies the distribution obligation of the other participants in the organized health care arrangement.

A health plan must distribute its privacy practices notice to each of its enrollees by its Privacy Rule compliance date. Thereafter, the health plan must give its notice to each new enrollee at enrollment, and send a reminder to every enrollee at least once every three years that the notice is available upon request. A health plan satisfies its distribution obligation by furnishing the notice to the "named insured," that is, the subscriber for coverage that also applies to spouses and dependents.

- **Acknowledgement of Notice Receipt.** A covered health care provider with a direct treatment relationship with individuals must make a good faith effort to obtain written acknowledgement from patients of receipt of the privacy practices notice.[54] The Privacy Rule does not prescribe any particular content for the acknowledgement. The provider must document the reason for any failure to obtain the patient's written acknowledgement. The provider is relieved of the need to request acknowledgement in an emergency treatment situation.

Access. Except in certain circumstances, individuals have the right to review and obtain a copy of their protected health information in a covered entity's designated record set.[55] The "designated record set" is that group of records maintained by or for a covered entity that is used, in whole or part, to make decisions about individuals, or that is a provider's medical and billing records about individuals or a health plan's enrollment, payment, claims adjudication, and case or medical management record systems.[56] The Rule excepts from the right of access the following protected health information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act (CLIA) prohibits access, or information held by certain research laboratories. For information included within the right of access, covered entities may deny an individual access in certain specified situations, such as when a health care professional believes access could cause harm to the individual or another. In such situations, the individual must be given the right to have such denials reviewed by a licensed health care professional for a second opinion.[57] Covered entities may impose reasonable, cost-based fees for the cost of copying and postage.

Amendment. The Rule gives individuals the right to have covered entities amend their protected health information in a designated record set when that information is inaccurate or incomplete. [58] If a covered entity accepts an amendment request, it must make reasonable efforts to provide the amendment to persons that the individual has

identified as needing it, and to persons that the covered entity knows might rely on the information to the individual's detriment.[59] If the request is denied, covered entities must provide the individual with a written denial and allow the individual to submit a statement of disagreement for inclusion in the record. The Rule specifies processes for requesting and responding to a request for amendment. A covered entity must amend protected health information in its designated record set upon receipt of notice to amend from another covered entity.

Disclosure Accounting. Individuals have a right to an accounting of the disclosures of their protected health information by a covered entity or the covered entity's business associates.[60] The maximum disclosure accounting period is the six years immediately preceding the accounting request, except a covered entity is not obligated to account for any disclosure made before its Privacy Rule compliance date.

The Privacy Rule does not require accounting for disclosures: (a) for treatment, payment, or health care operations; (b) to the individual or the individual's personal representative; (c) for notification of or to persons involved in an individual's health care or payment for health care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to health oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

Restriction Request. Individuals have the right to request that a covered entity restrict use or disclosure of protected health information for treatment, payment or health care operations, disclosure to persons involved in the individual's health care or payment for health care, or disclosure to notify family members or others about the individual's general condition, location, or death.[61] A covered entity is under no obligation to agree to requests for restrictions. A covered entity that does agree must comply with the agreed restrictions, except for purposes of treating the individual in a medical emergency.[62]

Confidential Communications Requirements. Health plans and covered health care providers must permit individuals to request an alternative means or location for receiving communications of protected health information by means other than those that the covered entity typically employs.[63] For example, an individual may request that the provider communicate with the individual through a designated address or phone number. Similarly, an individual may request that the provider send communications in a closed envelope rather than a post card.

Health plans must accommodate reasonable requests if the individual indicates that the disclosure of all or part of the protected health information could endanger the individual. The health plan may not question the individual's statement of endangerment. Any covered entity may condition compliance with a confidential communication request on the individual specifying an alternative address or method of contact and explaining how any payment will be handled.

Administrative Requirements

HHS recognizes that covered entities range from the smallest provider to the largest, multi-state health plan. Therefore the flexibility and scalability of the Rule are intended to allow covered entities to analyze their own needs and implement solutions appropriate for their own environment. What is appropriate for a particular covered entity will depend on the nature of the covered entity's business, as well as the covered entity's size and resources.

Privacy Policies and Procedures. A covered entity must develop and implement written privacy policies and procedures that are consistent with the Privacy Rule.[64]

Privacy Personnel. A covered entity must designate a privacy official responsible for developing and implementing its privacy policies and procedures, and a contact person or contact office responsible for receiving complaints and providing individuals with information on the covered entity's privacy practices.[65]

Workforce Training and Management. Workforce members include employees, volunteers, trainees, and may also include other persons whose conduct is under the direct control of the entity (whether or not they are paid by the entity).[66] A covered entity must train all workforce members on its privacy policies and procedures, as necessary and appropriate for them to carry out their functions.[67] A covered entity must have and apply appropriate sanctions against workforce members who violate its privacy policies and procedures or the Privacy Rule.[68]

Mitigation. A covered entity must mitigate, to the extent practicable, any harmful effect it learns was caused by use or disclosure of protected health information by its workforce or its business associates in violation of its privacy policies and procedures or the Privacy Rule.[69]

Data Safeguards. A covered entity must maintain reasonable and appropriate administrative, technical, and physical safeguards to prevent intentional or unintentional use or disclosure of protected health information in violation of the Privacy Rule and to limit its incidental use and disclosure pursuant to otherwise permitted or required use or disclosure.[70] For example, such safeguards might include shredding documents containing protected health information before discarding them, securing medical records with lock and key or pass code, and limiting access to keys or pass codes. See additional guidance on Incidental Uses and Disclosures.

Complaints. A covered entity must have procedures for individuals to complain about its compliance with its privacy policies and procedures and the Privacy Rule.[71] The covered entity must explain those procedures in its privacy practices notice.[72]

Among other things, the covered entity must identify to whom individuals can submit complaints to at the covered entity and advise that complaints also can be submitted to the Secretary of HHS.

Retaliation and Waiver. A covered entity may not retaliate against a person for exercising rights provided by the Privacy Rule, for assisting in an investigation by HHS or another appropriate authority, or for opposing an act or practice that the person believes in good faith violates the Privacy Rule.[73] A covered entity may not require an individual to waive any right under the Privacy Rule as a condition for obtaining treatment, payment, and enrollment or benefits eligibility.[74]

Documentation and Record Retention. A covered entity must maintain, until six years after the later of the date of their creation or last effective date, its privacy policies and procedures, its privacy practices notices, disposition of complaints, and other actions, activities, and designations that the Privacy Rule requires to be documented.[75]

Fully-Insured Group Health Plan Exception. The only administrative obligations with which a fully-insured group health plan that has no more than enrollment data and summary health information is required to comply are the (1) ban on retaliatory acts and waiver of individual rights, and (2) documentation requirements with respect to plan documents if such documents are amended to provide for the disclosure of protected health information to the plan sponsor by a health insurance issuer or HMO that services the group health plan.[76]

Organizational Options

The Rule contains provisions that address a variety of organizational issues that may affect the operation of the privacy protections.

Hybrid Entity. The Privacy Rule permits a covered entity that is a single legal entity and that conducts both covered and non-covered functions to elect to be a "hybrid entity."[77] (The activities that make a person or organization a covered entity are its "covered functions."[78]) To be a hybrid entity, the covered entity must designate in writing its operations that perform covered functions as one or more "health care components." After making this designation, most of the requirements of the Privacy Rule will apply only to the health care components. A covered entity that does not make this designation is subject in its entirety to the Privacy Rule.

Affiliated Covered Entity. Legally separate covered entities that are affiliated by common ownership or control may designate themselves (including their health care components) as a single covered entity for Privacy Rule compliance.[79] The designation must be in writing. An affiliated covered entity that performs multiple covered functions must operate its different covered functions in compliance with the Privacy Rule provisions applicable to those covered functions.

Organized Health Care Arrangement. The Privacy Rule identifies relationships in which participating covered entities share protected health information to manage and benefit their common enterprise as "organized health care arrangements."[80] Covered entities in an organized health care arrangement can share protected health information with each other for the arrangement's joint health care operations.[81]

Covered Entities With Multiple Covered Functions. A covered entity that performs multiple covered functions must operate its different covered functions in compliance with the Privacy Rule provisions applicable to those covered functions.[82] The covered entity may not use or disclose the protected health information of an individual who receives services from one covered function (e.g., health care provider) for another covered function (e.g., health plan) if the individual is not involved with the other function.

Group Health Plan disclosures to Plan Sponsors. A group health plan and the health insurer or HMO offered by the plan may disclose the following protected health

information to the "plan sponsor"—the employer, union, or other employee organization that sponsors and maintains the group health plan:[83]

- Enrollment or disenrollment information with respect to the group health plan or a health insurer or HMO offered by the plan.
- If requested by the plan sponsor, summary health information for the plan sponsor to use to obtain premium bids for providing health insurance coverage through the group health plan, or to modify, amend, or terminate the group health plan. "Summary health information" is information that summarizes claims history, claims expenses, or types of claims experience of the individuals for whom the plan sponsor has provided health benefits through the group health plan, and that is stripped of all individual identifiers other than five digit zip code (though it need not qualify as de-identified protected health information).
- Protected health information of the group health plan's enrollees for the plan sponsor to perform plan administration functions. The plan must receive certification from the plan sponsor that the group health plan document has been amended to impose restrictions on the plan sponsor's use and disclosure of the protected health information. These restrictions must include the representation that the plan sponsor will not use or disclose the protected health information for any employment-related action or decision or in connection with any other benefit plan.

Other Provisions: Personal Representatives and Minors

Personal Representatives. The Privacy Rule requires a covered entity to treat a *"personal representative"* the same as the individual, with respect to uses and disclosures of the individual's protected health information, as well as the individual's rights under the Rule.[84] A personal representative is a person legally authorized to make health care decisions on an individual's behalf or to act for a deceased individual or the estate. The Privacy Rule permits an exception when a covered entity has a reasonable belief that the personal representative may be abusing or neglecting the individual, or that treating the person as the personal representative could otherwise endanger the individual.

Special Case: Minors. In most cases, parents are the personal representatives for their minor children. Therefore, in most cases, parents can exercise individual rights, such as access to the medical record, on behalf of their minor children. In certain exceptional cases, the parent is not considered the personal representative. In these situations, the Privacy Rule defers to State and other law to determine the rights of parents to access and control the protected health information of their minor children. If State and other law is silent concerning parental access to the minor's protected health information, a covered entity has discretion to provide or deny a parent access to the minor's health information, provided the decision is made by a licensed health care professional in the exercise of professional judgment. See additional guidance on Personal Representatives.

State Law

Preemption. In general, State laws that are contrary to the Privacy Rule are preempted by the federal requirements, which means that the federal requirements will

apply.[85] "Contrary" means that it would be impossible for a covered entity to comply with both the State and federal requirements, or that the provision of State law is an obstacle to accomplishing the full purposes and objectives of the Administrative Simplification provisions of HIPAA.[86] The Privacy Rule provides exceptions to the general rule of federal preemption for contrary State laws that (1) relate to the privacy of individually identifiable health information and provide greater privacy protections or privacy rights with respect to such information, (2) provide for the reporting of disease or injury, child abuse, birth, or death, or for public health surveillance, investigation, or intervention, or (3) require certain health plan reporting, such as for management or financial audits.

Exception Determination. In addition, preemption of a contrary State law will not occur if HHS determines, in response to a request from a State or other entity or person, that the State law:

- Is necessary to prevent fraud and abuse related to the provision of or payment for health care,
- Is necessary to ensure appropriate State regulation of insurance and health plans to the extent expressly authorized by statute or regulation,
- Is necessary for State reporting on health care delivery or costs,
- Is necessary for purposes of serving a compelling public health, safety, or welfare need, and, if a Privacy Rule provision is at issue, if the Secretary determines that the intrusion into privacy is warranted when balanced against the need to be served; or
- Has as its principal purpose the regulation of the manufacture, registration, distribution, dispensing, or other control of any controlled substances (as defined in 21 U.S.C. 802), or that is deemed a controlled substance by State law.

Enforcement and Penalties for Noncompliance

Compliance. The Standards for Privacy of Individually Identifiable Health Information (Privacy Rule) establishes a set of national standards for the use and disclosure of an individual's health information – called protected health information – by covered entities, as well as standards for providing individuals with privacy rights to understand and control how their health information is used. The Department of Health and Human Services, Office for Civil Rights (OCR) is responsible for administering and enforcing these standards and may conduct complaint investigations and compliance reviews.

Consistent with the principles for achieving compliance provided in the Privacy Rule, OCR will seek the cooperation of covered entities and may provide technical assistance to help them comply voluntarily with the Privacy Rule. Covered entities that fail to comply voluntarily with the standards may be subject to civil money penalties. In addition, certain violations of the Privacy Rule may be subject to criminal prosecution. These penalty provisions are explained below.

Civil Money Penalties. OCR may impose a penalty on a covered entity for a failure to comply with a requirement of the Privacy Rule. Penalties will vary significantly depending on factors such as the date of the violation, whether the covered entity knew or should have known of the failure to comply, or whether the covered entity's failure to

comply was due to willful neglect. Penalties may not exceed a calendar year cap for multiple violations of the same requirement.

A penalty will not be imposed for violations in certain circumstances, such as if:

- the failure to comply was not due to willful neglect, and was corrected during a 30-day period after the entity knew or should have known the failure to comply had occurred (unless the period is extended at the discretion of OCR); or
- the Department of Justice has imposed a criminal penalty for the failure to comply (see below).

In addition, OCR may choose to reduce a penalty if the failure to comply was due to reasonable cause and the penalty would be excessive given the nature and extent of the noncompliance.

Before OCR imposes a penalty, it will notify the covered entity and provide the covered entity with an opportunity to provide written evidence of those circumstances that would reduce or bar a penalty. This evidence must be submitted to OCR within 30 days of receipt of the notice. In addition, if OCR states that it intends to impose a penalty, a covered entity has the right to request an administrative hearing to appeal the proposed penalty.

Criminal Penalties. A person who knowingly obtains or discloses individually identifiable health information in violation of the Privacy Rule may face a criminal penalty of up to $50,000 and up to one-year imprisonment. The criminal penalties increase to $100,000 and up to five years imprisonment if the wrongful conduct involves false pretenses, and to $250,000 and up to 10 years imprisonment if the wrongful conduct involves the intent to sell, transfer, or use identifiable health information for commercial advantage, personal gain or malicious harm. The Department of Justice is responsible for criminal prosecutions under the Priv

Compliance Dates

Compliance Schedule. All covered entities, except "small health plans," must have been compliant with the Privacy Rule by April 14, 2003.[90] Small health plans, however, had until April 14, 2004 to comply.

Small Health Plans. A health plan with annual receipts of not more than $5 million is a small health plan.[91] Health plans that file certain federal tax returns and report receipts on those returns should use the guidance provided by the Small Business Administration at 13 Code of Federal Regulations (CFR) 121.104 to calculate annual receipts. Health plans that do not report receipts to the Internal Revenue Service (IRS), for example, group health plans regulated by the Employee Retirement Income Security Act 1974 (ERISA) that are exempt from filing income tax returns, should use proxy measures to determine their annual receipts.[92] See What constitutes a small health plan?

Copies of the Rule & Related Materials

See our Combined Regulation Text of All Rules section of our site for the full suite of HIPAA Administrative Simplification Regulations and Understanding HIPAA for additional guidance material.

What Is a Conditional Binding Receipt?

A conditional binding receipt is involved in life, health, and certain property insurance contracts; if the insured is deemed to be covered by the insurer, the coverage begins on the date the insured receives the conditional binding receipt.

Typically, a premium payment must be received by the insurer along with a completed acceptable application in order for the insured to obtain the receipt. This may also be called a "conditional receipt" or a "binding receipt," depending on the type of insurance.

Key Takeaways

- A conditional binding receipt is involved in life, health, and certain property insurance contracts.
- If the insured is deemed to be covered by the insurer, the coverage begins on the date the insured receives the conditional binding receipt.
- A life and health insurance policy without a conditional binding receipt is not effective until it is delivered to the insured and the premium is paid.
- The function of a conditional binding receipt can actually be divided into two separate receipts: a conditional receipt and a binding receipt.

Understanding Conditional Binding Receipts

If a premium accompanies an application, a conditional binding receipt provides that coverage will be in force from the date of application or medical examination, so long as the insurer would have issued the coverage on the basis of the facts revealed on the application, medical examination, and other usual sources of underwriting information. A life and health insurance policy without a conditional binding receipt is not effective until it is delivered to the insured and the premium is paid.

So long as the insured is going to receive the policy anyway, the insurer is obliged to cover a claim should one occur between the time the application is received and the time the policy is officially in place. If, however, the insured is denied coverage as the typical underwriting process progresses, the insurer could nullify the conditional binding receipt, even if a premium was collected.

The function of a conditional binding receipt can actually be divided into two separate receipts: a conditional receipt and a binding receipt.

Conditional Receipts

The conditional receipt is most common. Under a conditional receipt, the applicant and the insurance company form a "conditional" contract that is contingent upon the conditions that existed when an application or medication exam is completed. It provides that the applicant is covered immediately as long as they pass the insurer's underwriting requirements. It is the insurance agent's responsibility to tell the applicant they are covered on the condition they prove to be insurable and pass a medical exam if one is required.

A conditional receipt gives an insurance company a window of time in which they can ultimately issue or refuse to approve the policy. If during this time, the applicant for a life

insurance contract dies, the company will pay a death benefit if the policy would have been issued.

Binding Receipts

A binding receipt states an insurance policy is effective upon receipt of initial premium payment. However, should the insured die before the application is processed, benefits are fully payable, subject to limitations.

The binding receipt binds an insurer to the agreement unconditionally when benefits are due up to the limits of the policy.

Face-to-Face Delivery

It is critical to promptly deliver all policies and contracts to customers. Prompt delivery helps:

- Initiate the timing of the free-look period
- Ensure customer receives quality service
- Build relationships between financial professional and customers
- Obtain high quality referrals
- Enhance the financial professional's professional image
- Improve persistency

Examination Offer

The examination offer is a standard provision in all current contracts. It entitles the owner to a refund if cancellation of the policy within ten days (in most cases) of the date the contract is delivered.

The examination offer on such requests starts when the owner receives the contract—not when it's mailed from the home office or received by the financial professional. Therefore, it is essential that the policy be delivered promptly and a delivery receipt secured.

If Financial Professional...	Possible Outcomes...	Then...
Delays delivery	• Violation of company policy • Free look period does not begin until delivery to customer • Policy or Contract may be made not taken, resulting in reversed commissions • Loss of goodwill and referrals	Agency management must: • Deliver policy/contract • Obtain signed delivery receipt • Advise customer of free look period • Counsel financial professional on company delivery policies and ensure all are promptly delivered

	• Customer complaint • Harm to reputation (financial professional's and company's) • Business Conduct review • Sanctions against financial professional	
Does not obtain signed delivery receipt	• Violation of company policy • Free look period may not begin until signed by owner • Policy or contract may be made not taken, resulting in reversed commissions • Loss of goodwill and referrals • Customer complaint • Errors and Omissions Claim • Harm to reputation • Business Conduct review • Sanctions against financial professional	Agency management must: • Deliver policy/contract • Obtain signed delivery receipt • Advise customer of free look period • Counsel financial professional on company delivery policies and ensure all are promptly delivered
Accepts or requests from customer, or submits, delivery receipt signed by someone other than customer	• Violation of company policy • Violation of confidentiality or privacy • Void delivery receipt • New free look period may be required • Commission reversal • Customer complaint	Agency management: • Assists home office with Business Conduct • Delivers policy/contract • Obtain signed delivery receipt • Advises customer of free look period • Reviews any actions taken with financial professional

	• Business Conduct review • Jeopardize contract with Principal Life • Sanctions against financial professional	
Miscommunicates medical information	• Violation of privacy or confidentiality laws • Customer complaint • Business Conduct Review • Jeopardize contract with Principal Life • Sanctions against financial professional	Agency management: • Application may be declined • Deliver policy/contract • Obtain signed delivery receipt • Advises customer of free look period • Assists home office with Business Conduct review and any actions taken with financial professional
Keeps Possession of Policy or Contract	• Violation of company delivery requirements • Violation of state regulations • Void delivery receipt • New free look period may be required • Commission reversal • Customer complaint • Errors and Omissions Claim • Jeopardize contract with Principal Life • Business Conduct review • Sanctions against financial professional	Agency management: • Delivers policy/contract • Obtains signed delivery receipt • Advises customer of free look period • Assists home office with Business Conduct review and any actions taken with financial professional

Opens Personal and Confidential letter prior to delivery to customer	• Violation of company policy • Violation of privacy or confidentiality laws • Customer complaint • Business Conduct Review • Jeopardize contract with Principal Life • Sanctions against financial professional	Agency management: • Notifies Business Conduct and Underwriter • Assists home office with Business Conduct review and any actions taken with financial professional • Assists home office with any action taken with customer
Does not deliver Buyer's Guide	• Violation of state regulation • Violation of company policy • Customer complaint • Business Conduct Review • Jeopardize contract with Principal Life • Sanctions against financial professional	Agency management must: • Deliver policy/contract and Buyer's Guide • Obtained signed delivery receipt • Advise customer of free look period • Assist home office with Business Conduct review and any actions taken regarding financial professional

Delivery by Mail

Applications which were taken by mail might result in having to deliver the policy or contract issued by mail. The financial professional must:

1. Comply with all company guidelines, policies, and state requirements.
2. Call the customer as soon as possible after receiving the policy/contract.
3. Review with the customer the policy/contract, delivery receipt, amendment forms, and riders.
4. Mail the policy/contract and other required forms to the customer.
5. Follow up regularly to ensure delivery receipt, signed Part D and any other delivery requirements are promptly signed and returned.

Elements Of an Insurance Contract

What Does Elements Of An Insurance Contract Mean?

The elements of an insurance contract are the standard conditions that must be satisfied or agreed upon by both parties of the contract (the insured and the insurance

company). In terms of insurance, these are the fundamental conditions of the insurance contract that bind both parties, validate the policy, and make it enforceable by law.

By signing the insurance contract, you have essentially agreed to follow the different elements. Without all of the elements of an insurance contract present, the policy may not be valid, and that means the obligations of both parties may not be enforceable in court.

The elements of an insurance contract are very similar to the elements required for any other legally binding contract with a few extra elements that are special to insurance contracts. You need both types of elements to be present before a valid and proper insurance policy is produced.

Explanation of the Elements of An Insurance Contract

In order for an insurance contract to be legally binding, the document must meet the essential elements required of all legally binding contracts, plus a few special elements that are specific to and required by insurance contracts.

First let us talk about the elements required of legally binding contracts in general:

- **Offer and Acceptance** – This refers to an offering being made and then being accepted by the other party. When you fulfill this legal requirement, you are saying that all of the negotiations have been settled and you've come to an agreement. This is also often called "agreement" or a "meeting of the minds". In the insurance context, that means you have made an application to the insurance company, they have accepted it and you have accepted the policy terms they offered.
- **Consideration** – This refers to a fair exchange of value. A contract where one party gets everything while another party contributes nothing does not meet this requirement. In the example of an insurance policy, you are paying them premiums while they are providing you with a promise to pay claims in the future.
- **Legal Capacity** – To satisfy this requirement, everyone that is a party to the contract must have the legal capacity or competence to enter into a contract. This means you have to meet certain requirements such as being above the age of majority in your jurisdiction and have the mental capacity to understand what you are signing and agreeing to.
- **Legal Purpose** – Obviously, the courts will not enforce a contract that is not legal. For example, a contract for the provision of illegal services would not be a legal and valid contract because the course would not enforce it.

The other elements required are specific to insurance contracts:

- Indemnity.
- Insurable Interest.
- Utmost Good Faith.
- Subrogation.
- Assignment and nomination.

- Warranties.
- Proximate Cause.
- Return of Premium.

What Does Adhesion Insurance Contract Mean?

Adhesion Insurance contract is a contract where one party states the provisions of the contract while the other party is not involved in its drafting, but whose participation is in either agreeing with it or declining it. An insurance policy is known as an adhesion contract.

In most contracts, all parties are involved in the wording or the details before they reach an agreement and make it legally binding. In insurance, that is not the case. The standard insurance policy already has its own terms and conditions before it is signed and bought by the insured. The participation of the insurance client is often only about consenting or dissenting (by not buying) with the policy presented to him or her. That explains why an insurance contract is considered as an adhesion contract.

However, there are policies in which the policyholder can make modifications by way of riders. In some automobile insurance policies, the insured can add a provision later on such as adding more risks to be covered or adding more names in the policy.

What Is an Aleatory Contract?

An aleatory contract is an agreement whereby the parties involved do not have to perform a particular action until a specific, triggering event occurs. Events are those that cannot be controlled by either party, such as natural disasters and death. Aleatory contracts are commonly used in insurance policies. For example, the insurer does not have to pay the insured until an event, such as a fire that results in property loss. Aleatory contracts—also called aleatory insurance—are helpful because they typically help the purchaser reduce financial risk.1

Key Takeaways

- An aleatory contract is an agreement whereby the parties involved do not have to perform a particular action until a specific event occurs.
- The trigger events aleatory contracts are those that cannot be controlled by either party, such as natural disasters or death.
- Insurance policies use aleatory contracts whereby the insurer doesn't have to pay the insured until an event, such as a fire resulting in property loss.1

Understanding an Aleatory Contract

Aleatory contracts are historically related to gambling and appeared in Roman law as contracts related to chance events. In insurance, an aleatory contract refers to an insurance arrangement in which the payouts to the insured are unbalanced. Until the insurance policy results in a payout, the insured pays premiums without receiving anything in return besides coverage. When the payouts do occur, they can far outweigh the sum of premiums paid to the insurer. If the event does not occur, the promise outlined in the contract will not be performed.

How Aleatory Contracts Work

Risk assessment is an important factor to the party, taking a higher risk when considering entering into an aleatory contract. Life insurance policies are considered aleatory contracts, as they do not benefit the policyholder until the event itself (death) comes to pass. Only then will the policy allow the agreed amount of money or services stipulated in the aleatory contract. The death of someone is an uncertain event as no one can predict in advance with certainty that when the insured will die. However, the amount which the insured's beneficiary will receive is certainly much more than what the insured has paid as a premium.

In certain cases, if the insured has not paid the regular premiums to keep the policy in force, the insurer is not obliged to pay the policy benefit, even though an insured has made some premium payments for the policy. In other types of insurance contracts, if the insured doesn't die during the policy term, then nothing will be payable on maturity, such as with term life insurance.

Annuities and Aleatory Contracts

Another type of aleatory contract where each party takes on a defined level of risk exposure is an annuity. An annuity contract is an agreement between an individual investor and an insurance company whereby the investor pays a lump sum or a series of premiums to the annuity provider. In return, the contract legally binds the insurance company to pay periodic payments to the annuity holder—called the annuitant—once the annuitant reaches a certain milestone, such as retirement. However, the investor might risk losing the premiums paid into the annuity if they withdraw the money too early. On the other hand, the person might live a long life and receive payments that far exceed the original amount that was paid for the annuity.

Annuity contracts can be very helpful to investors, but they can also be extremely complex. There are various types of annuities each with its own rules that include how and when payouts are structured, fee schedules, and surrender charges—if money is withdrawn too soon.

Georgia State Laws Dealing with Insurance

Georgia Code § 33-2-1 through 6; 9 through 32

2023 CODE OF GEORGIA

Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)

Chapter 2 - DEPARTMENT AND COMMISSIONER OF INSURANCE (§§ 33-2-1 — 33-2-34)

Section 33-2-1 - Creation of department; Commissioner chief officer of department; powers and duties of department and Commissioner generally

There is created the Department of Insurance of the State of Georgia. The chief officer of such department shall be the Commissioner of Insurance. The purpose and function of the department and the duties and powers of the Commissioner shall be those created and vested by this title.

Amended by 2019 Ga. Laws 139,§ 1-9, eff. 7/1/2019.

Georgia Code § 33-2-10 through 13

2023 CODE OF GEORGIA

Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)

Chapter 2 - DEPARTMENT AND COMMISSIONER OF INSURANCE (§§ 33-2-1 — 33-2-34)

Section 33-2-11 - Examination of insurers and organizations; effect of insurer's change of domicile from Georgia

Universal Citation:

GA Code § 33-2-11 (2023)

Learn more

Previous

Next

(a) Whenever the Commissioner shall deem it expedient, the Commissioner shall examine, either in person or by some examiner duly authorized by the Commissioner, the affairs, transactions, accounts, records, documents, and assets of each insurer authorized to do business in this state and any other facts relative to its business methods, management, and dealings with policyholders. At least once every five years, the Commissioner shall so examine each domestic insurer. Examination of an alien insurer shall be limited to its insurance transactions in the United States.

(b) Whenever he shall deem it necessary at least once in five years, the Commissioner shall fully examine each rating organization which is licensed in this state. As often as he shall deem it necessary, he may examine each advisory organization and each joint underwriting or joint reinsurance group, association, or organization.

(c) The Commissioner shall in like manner examine each insurer or rating organization applying for authority to do business in this state.

(d) In lieu of an examination under this Code section of any foreign or alien insurer licensed in this state, the Commissioner may accept an examination report on such insurer as prepared by the insurance department of such insurer's state of domicile or port-of-entry state until January 1, 1994. On and after January 1, 1994, such reports may be accepted only if:

(1) The insurance department was, at the time the examination was conducted, accredited under the National Association of Insurance Commissioners' financial regulation standards and accreditation program; or

(2) The examination was performed under the supervision of an accredited insurance department or with the participation of one or more examiners who are employed by an accredited state insurance department and who, after a review of the examination work papers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by their insurance department.

(e) Any insurer authorized to transact insurance in this state which changes its domicile from Georgia to another state on or after April 1, 1988, may be examined by the

Commissioner once a year for five years, beginning on or after the occurrence of the change in domicile; provided, however, this subsection shall not apply to an insurer which changes its domicile from Georgia to another state as long as it retains in this state its principal place of business and the complete records of its assets, transactions, and affairs.

Amended by 2008 Ga. Laws 769,§ 1, eff. 7/1/2008.

Georgia Code § 33-6-6

Report Complaints & Fraud

Consumer Complaints

The Consumer Services Department is the investigative arm of OCI. Our job is to ensure fair and equitable dealings between insurers, agents, and policyholders. If you have a complaint about your insurance provider or agent, or how a claim is being handled, we may be able to help you resolve the issue.

Consumers and providers may also use our complaint portal to report suspected mental health parity violations by Georgia insurers.

How to file a consumer complaint

Insurance Fraud

The mission of the Office of the Commissioner of Insurance and Safety Fire Criminal Investigations Division (OCI-CID) is to protect Georgia citizens against economic loss and victimization by thoroughly investigating individuals and criminal organizations suspected of committing fraudulent insurance acts and other related crimes.

How to report suspected insurance fraud

Managed Care Complaints

The Consumer Services Division works to resolve complex claims problems between health care providers and managed care insurers. If you are a provider with a complaint, submitting using the **Consumer Complaint Portal** is the preferred and quickest complaint process.

Georgia Code § 33-6-9

2023 CODE OF GEORGIA
Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)
Chapter 1 - GENERAL PROVISIONS (§§ 33-1-1 — 33-1-27)
Section 33-1-9 - Insurance fraud; venue; penalty; exemption

- **(a)** Any natural person who knowingly or willfully:
  - **(1)** Makes or aids in the making of any false or fraudulent statement or representation of any material fact or thing:
    - **(A)** In any written statement or certificate;
    - **(B)** In the filing of a claim;
    - **(C)** In the making of an application for a policy of insurance;

- **(D)** In the receiving of such an application for a policy of insurance; or
- **(E)** In the receiving of money for such application for a policy of insurance

for the purpose of procuring or attempting to procure the payment of any false or fraudulent claim or other benefit by an insurer;

- **(2)** Receives money for the purpose of purchasing insurance and converts such money to such person's own benefit;
- **(3)** Issues fake or counterfeit insurance policies, certificates of insurance, insurance identification cards, or insurance binders; or
- **(4)** Makes any false or fraudulent representation as to the death or disability of a policy or certificate holder in any written statement or certificate for the purpose of fraudulently obtaining money or benefit from an insurer

commits the crime of insurance fraud.

- **(b)** Any natural person who knowingly and willfully or with reckless disregard engages in the following activities, either directly or indirectly, as an agent for, as a representative of, or on behalf of an insurer not authorized to transact insurance in this state commits the crime of insurance fraud:
  - **(1)** Soliciting, negotiating, procuring, or effectuating insurance or annuity contracts or renewals thereof;
  - **(2)** Soliciting, negotiating, procuring, or effectuating any contract relating to benefits or services;
  - **(3)** Disseminating information as to coverage or rates;
  - **(4)** Forwarding applications;
  - **(5)** Delivering policies or contracts;
  - **(6)** Inspecting or assessing risk;
  - **(7)** Fixing of rates;
  - **(8)** Investigating or adjusting claims or losses;
  - **(9)** Collecting or forwarding of premiums; or
  - **(10)** In any other manner representing or assisting such an insurer in the transaction of insurance with respect to subjects of insurance resident, located, or to be performed in this state.
- **(c)** Any natural person who knowingly and willfully with intent to defraud subscribes, makes, or concurs in making any annual or other statement required by law to be filed with the Commissioner containing any material statement which is false commits the crime of insurance fraud.
- **(d)** In any prosecution under this Code section, the crime shall be considered as having been committed in the county of the purported loss, in the county in which the

insurer or the insurer's agent received the fraudulent or false claim or application, in the county in which money was received for the fraudulent application, or in any county where any act in furtherance of the criminal scheme was committed.

- **(e)** A natural person convicted of a violation of this Code section shall be guilty of a felony and shall be punished by imprisonment for not less than two nor more than ten years, or by a fine of not more than $10,000.00, or both.
- **(f)** Subsection (b) of this Code section shall not apply to a contract of insurance entered into in accordance with Article 2 of Chapter 5 of this title.

Amended by 2004 Ga. Laws 583, § 1A, eff. 5/13/2004.

Amended by 2003 Ga. Laws 276, § 1, eff. 6/3/2003.

Amended by 2003 Ga. Laws 97, § 1.2, eff. 5/30/2003.

Georgia Code § 33-3-1

2023 CODE OF GEORGIA
Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)
Chapter 3 - AUTHORIZATION AND GENERAL REQUIREMENTS FOR TRANSACTION OF INSURANCE (§§ 33-3-1 — 33-3-30)
Section 33-3-1 - Definitions

As used in this chapter, the term:

- **(1)** "Administrative supervision" means the continued operation of the company under supervision of the Commissioner in accordance with regulations promulgated by the Commissioner.
- **(2)** "Alien" insurer means an insurer formed under the laws of a country other than the United States.
- **(3)** "Charter" means articles of incorporation, articles of agreement, articles of association, or other basic constituent document of a corporation; subscribers' agreement and power of attorney of a reciprocal insurer; or underwriters' agreement and power of attorney of a Lloyd's insurer.
- **(4)** "Domestic" insurer means an insurer formed under the laws of Georgia.
- **(5)** "Foreign" insurer means an insurer formed under the laws of another state or government of the United States.
- **(6)** "State" means any state, commonwealth, territory, or district of the United States.
- **(7)** "United States" includes the states, territories, districts, and commonwealths of the United States.

Georgia Code § 33-14-2

2023 CODE OF GEORGIA
Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)
Chapter 14 - DOMESTIC STOCK AND MUTUAL INSURERS (§§ 33-14-1 — 33-14-

128)
Article 1 - GENERAL PROVISIONS (§§ 33-14-1 — 33-14-27)
Section 33-14-2 - Definitions

As used in this chapter, the term:

- **(1)** "Mutual insurer" means an incorporated insurer without capital stock or shares which is owned and governed by its policyholders.
- **(2)** "Stock insurer" means an incorporated insurer with capital divided into shares and owned by its shareholders.

Georgia Code § 33-3-2 through 5; 33-3-13 through 30

2023 CODE OF GEORGIA
Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)
Chapter 3 - AUTHORIZATION AND GENERAL REQUIREMENTS FOR TRANSACTION OF INSURANCE (§§ 33-3-1 — 33-3-30)
Section 33-3-2 - Certificate of authority required for transaction of insurance within state; exceptions

- **(a)** No person shall act as an insurer and no insurer shall transact insurance in Georgia except as authorized by a subsisting certificate of authority granted to it by the Commissioner, except as to any transactions as are expressly otherwise provided for in this title.
- **(b)** The mere investigation and adjustment of any claim in this state arising under an insurance contract and litigation in connection therewith shall not be deemed to constitute the transacting of insurance in this state.
- **(c)** An insurer not transacting new insurance business in Georgia but continuing collection of premiums on and servicing of policies remaining in force as to residents of or risks located in Georgia is transacting insurance in Georgia for the purpose of premium tax requirements only and is not required to have a certificate of authority therefor.
- **(d)** As to an insurance coverage on a subject of insurance not resident, located, or expressly to be performed in Georgia at time of issuance and solicited, written, and delivered outside Georgia, no certificate of authority shall be required of an insurer as to subsequent transactions in Georgia on account of such insurance; and this title shall not apply to such insurance or insurance coverage, except for the purpose of premium tax requirements.

2023 CODE OF GEORGIA
Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)
Chapter 3 - AUTHORIZATION AND GENERAL REQUIREMENTS FOR TRANSACTION OF INSURANCE (§§ 33-3-1 — 33-3-30)
Section 33-3-3 - Qualifications for transaction of insurance generally; transaction of insurance by insurers owned by states, foreign governments

- **(a)** To qualify for and hold authority to transact insurance in Georgia an insurer must be otherwise in compliance with the provisions of this title and with its charter powers and must be an incorporated stock insurer, an incorporated mutual insurer, a fraternal benefit society, a farmers' mutual fire insurance company, a Lloyd's association, or a reciprocal insurer of the same general type as may be formed as a domestic insurer under this title, except that no foreign or alien insurer shall be authorized to transact insurance in Georgia which does not maintain reserves as required by Chapter 10 of this title applicable to the kind or kinds of insurance transacted in the United States by such insurer.

- **(b)** No certificate of authority or license to transact any kind of insurance business in this state shall be issued, renewed, or continued in effect to any domestic, foreign, or alien insurance company or other insurance entity which is owned or financially controlled in whole or in substantial part by any state of the United States, by a foreign government, or by any political subdivision, instrumentality, or agency of either or which is an agency of such state or foreign government or any political subdivision, instrumentality, or agency of either unless such company or entity was so owned, controlled, or constituted prior to January 1, 1957, and was authorized to do business in this state on or prior to said date.

- **(c)** Membership in a mutual insurer, subscribership in a reciprocal insurer, or supervision of an insurer by a public insurance supervisory authority shall not be deemed to be an ownership, control, or operation of the insurer for the purposes of subsection (b) of this Code section.

Amended by 2017 Ga. Laws 52,§ 5, eff. 7/1/2017.

2023 CODE OF GEORGIA
Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)
Chapter 3 - AUTHORIZATION AND GENERAL REQUIREMENTS FOR TRANSACTION OF INSURANCE (§§ 33-3-1 — 33-3-30)
Section 33-3-4 - Kinds of insurance in which insurers may transact

An insurer which otherwise qualifies to transact insurance in Georgia may be authorized to transact any one kind or combination of kinds of insurance as defined in Chapter 7 of this title except:

- **(1)** A reciprocal insurer shall not transact life insurance;

- **(2)** A Lloyd's insurer shall not transact life insurance; and

- **(3)** A title insurer shall be a stock insurer and shall be authorized to transact only title insurance and closing protection letters, pursuant to Code Section 33-7-8.1.

Amended by 2019 Ga. Laws 139,§ 1-15, eff. 7/1/2019.

Amended by 2012 Ga. Laws 734,§ 1, eff. 5/2/2012.

2023 CODE OF GEORGIA
Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)
Chapter 3 - AUTHORIZATION AND GENERAL REQUIREMENTS FOR TRANSACTION OF INSURANCE (§§ 33-3-1 — 33-3-30)
Section 33-3-5 - Classification of kinds of insurance

For the purpose of this chapter, the kinds of insurance defined in Chapter 7 of this title shall be arranged in the following six classes:

- **(1)** Life, accident, and sickness;
- **(2)** Property, marine, and transportation;
- **(3)** Casualty;
- **(4)** Surety;
- **(5)** Title; and
- **(6)** Health maintenance organization.

Each of the groups numbered (1) through (6) shall constitute a class of insurance.

Amended by 2019 Ga. Laws 139,§ 1-16, eff. 7/1/2019.

2023 CODE OF GEORGIA
Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)
Chapter 3 - AUTHORIZATION AND GENERAL REQUIREMENTS FOR TRANSACTION OF INSURANCE (§§ 33-3-1 — 33-3-30)
Section 33-3-13 - Information required in or attached to application for certificate of authority

PreviousNext

To apply for an original certificate of authority an insurer shall file with the Commissioner its application therefor showing its name, location of its home office or its existing or proposed principal office in the United States if an alien insurer, kinds of insurance to be transacted, date of organization or incorporation, form of organization, state or country of domicile, the names and addresses of all general officers of the company with the number of shares of capital stock of the company held by or for each such general officer or by others for his or her benefit, and the percentage of the total capital stock of the company held by each such general officer, the date on which the company began to do business, the states in which it is admitted to do business, and such additional information as the Commissioner may require, together with the following applicable documents:

- **(1)** A copy of its corporate charter with all amendments thereto certified by the public officer with whom the originals are on file in the state or country of domicile;
- **(2)** A copy of its bylaws, as amended, certified by its secretary or other officer having custody thereof;
- **(3)** If a foreign or alien insurer, a copy of its annual statement as of December 31 of the preceding year in a form approved for current use by the Commissioner and certified by two officers of the company. The annual statement of an alien insurer which has entered through and the United States branch of which is licensed to transact insurance in another state shall relate only to the transactions and affairs in the United States unless the Commissioner requires otherwise;

- **(4)** A copy of report of the last examination, if any, made of the insurer, certified by the insurance supervisory official of its state or country of domicile or of entry into the United States;
- **(5)** If a foreign or alien insurer, a copy of the appointment of the Commissioner as its attorney to receive service of legal process;
- **(6)** If a foreign or alien insurer, a certificate of the public official having supervision of insurance in its state or country of domicile showing that it is authorized to transact the kinds of insurance proposed to be transacted in Georgia;
- **(7)** If an alien insurer, a copy of the appointment and authority of its United States manager certified by its officer having custody of its records;
- **(8)** If a foreign or alien insurer, certificate as to deposit if to be tendered pursuant to Code Section 33-3-8; and
- **(9)** If an alien insurer entering through this state to transact insurance in the United States through a United States branch, an English language translation, as necessary, of any of the documents required under this Code section.

2023 CODE OF GEORGIA

Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)

Chapter 3 - AUTHORIZATION AND GENERAL REQUIREMENTS FOR TRANSACTION OF INSURANCE (§§ 33-3-1 — 33-3-30)

Section 33-3-14 - Application fee

Every original application shall be accompanied by the fee required by Code Section 33-8-1, which shall be returned to the applicant if the application is finally denied.

2023 CODE OF GEORGIA
Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)
Chapter 3 - AUTHORIZATION AND GENERAL REQUIREMENTS FOR TRANSACTION OF INSURANCE (§§ 33-3-1 — 33-3-30)
Section 33-3-15 - Issuance or refusal of certificate of authority generally; determining whether insurer meets definition of reinsurer; designation on certificate

- **(a)** Upon filing of an application for an original certificate of authority, the Commissioner shall have 90 days in which to approve the application by issuing an appropriate certificate of authority or disapprove the application by issuing an order setting forth the grounds for such disapproval. The Commissioner may extend such 90 day period for an additional 90 days by notifying the applicant in writing of such extension. If the application is not approved or disapproved within such time period or periods, the application shall be deemed approved and the Commissioner shall thereupon issue the appropriate certificate of authority.
- **(b)** The certificate, if issued, shall specify the kind or kinds of insurance the insurer is authorized to transact in Georgia. At the insurer's request, the Commissioner may issue a certificate of authority limited to particular types of insurance included within a kind of insurance as defined in this title.

- **(c)** The Commissioner shall determine if the insurer is a reinsurer and shall so designate on the certificate. As used in this subsection, the term "reinsurer" means an insurer that is principally engaged in the business of reinsurance, does not conduct significant amounts of direct insurance as a percentage of its net premiums, and is not engaged in an ongoing basis in the business of soliciting direct insurance.

Amended by 2011 Ga. Laws 218,§ 1, eff. 7/1/2011.

2023 CODE OF GEORGIA
Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)
Chapter 3 - AUTHORIZATION AND GENERAL REQUIREMENTS FOR TRANSACTION OF INSURANCE (§§ 33-3-1 — 33-3-30)
Section 33-3-16 - Expiration of certificate; procedure for renewal; amendment of certificate by Commissioner

PreviousNext

- **(a)** All certificates of authority shall expire at 12:00 Midnight on June 30 of the year following date of issuance or renewal. An insurer desiring renewal shall file on March 1 preceding expiration a copy of its annual statement of December 31 of the preceding year in a form approved for current use by the Commissioner. On or before March 1 of each year, each insurer at its expense shall publish in a newspaper of general circulation published in this state a copy of such statement in short form showing income, assets, expenditures, and liabilities in gross as of December 31 of the preceding year to be sworn to by the officer or agent making the same; and such statement so published must be filed with the Commissioner with a copy of the statement as published attached thereto. Notwithstanding the March 1 deadline, the Commissioner may for good cause grant an extension of time for filing such annual statement not to exceed 60 days. If the insurer qualifies, its certificate shall be renewed annually; provided, however, that any certificate of authority shall continue in full force and effect until the new certificate is issued or specifically refused.

- **(b)** The Commissioner may amend a certificate of authority at any time to accord with changes in the insurer's charter or insuring powers.

2023 CODE OF GEORGIA
Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)
Chapter 3 - AUTHORIZATION AND GENERAL REQUIREMENTS FOR TRANSACTION OF INSURANCE (§§ 33-3-1 — 33-3-30)
Section 33-3-17 - Discretionary refusal, revocation, or suspension of certificate generally

In addition to any other grounds set forth in this title, the Commissioner may refuse to issue a certificate of authority or after a hearing refuse to renew or may revoke or suspend an insurer's certificate of authority or place an insurer under administrative supervision if the insurer:

- **(1)** Violates any provision of this title other than those as to which refusal, suspension, or revocation is mandatory;

- **(2)** Knowingly fails to comply with or violates any rule, regulation, or order of the Commissioner;

- **(3)** Is found by the Commissioner to be in unsound condition or in such condition as to render its further transaction of insurance in Georgia hazardous to its policyholders or to the public;
- **(4)** As a general scheme or plot without just cause compels claimants to accept less than the amount due them or to bring an action against it to secure full payment thereof;
- **(5)** Refuses to be examined or to produce its accounts, records, and files for examination by the Commissioner when required; or refuses to furnish such other additional information as the Commissioner may deem necessary to consider the application for renewal of such insurer's certificate of authority;
- **(6)** Fails to pay any final judgment rendered against it in Georgia within 30 days after such judgment becomes final; or
- **(7)** Is affiliated with and under the same general management or interlocking directorate or ownership as another insurer which transacts direct insurance in Georgia without having a certificate of authority therefor, except as permitted to a surplus line insurer under Chapter 5 of this title or an insurance holding company under Chapter 13 of this title.

2023 CODE OF GEORGIA
Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)
Chapter 3 - AUTHORIZATION AND GENERAL REQUIREMENTS FOR TRANSACTION OF INSURANCE (§§ 33-3-1 — 33-3-30)
Section 33-3-18 - Administrative supervision or suspension of certificate of authority for cause

The Commissioner may, without advance notice or a hearing thereon, place an insurer under administrative supervision or suspend immediately the certificate of authority of any insurer:

- **(1)** As to which proceedings for receivership, conservatorship, rehabilitation, or other delinquency proceedings have been commenced in any state by the public insurance supervisory official of such state;
- **(2)** Whose authority to do business in any state has been revoked, suspended, or restricted in any way by the public insurance supervisory official of such state; or
- **(3)** If upon examination or at any other time it appears in the Commissioner's discretion that:
  - **(A)** The insurer's condition renders the continuance of its business hazardous to the public or to its insureds;
  - **(B)** The insurer exceeded its powers granted under its certificate of authority and applicable law;
  - **(C)** The insurer has failed to comply with the applicable provisions of this title;
  - **(D)** The business of the insurer is being conducted fraudulently; or

- **(E)** The insurer gives its consent.

2023 CODE OF GEORGIA
Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)
Chapter 3 - AUTHORIZATION AND GENERAL REQUIREMENTS FOR TRANSACTION OF INSURANCE (§§ 33-3-1 — 33-3-30)
Section 33-3-19 - Mandatory refusal, revocation, or suspension of certificate

The Commissioner shall refuse to issue or to renew or shall revoke or suspend an insurer's certificate of authority:

- **(1)** If such action is required by any provision of this title; or
- **(2)** If the insurer no longer meets the requirements for the authority originally granted on account of deficiency in assets or otherwise.

2023 CODE OF GEORGIA
Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)
Chapter 3 - AUTHORIZATION AND GENERAL REQUIREMENTS FOR TRANSACTION OF INSURANCE (§§ 33-3-1 — 33-3-30)
Section 33-3-20 - Imposition of administrative fine upon insurer for certain acts of officers, employees, agents, or representatives

- **(a)** The Commissioner may, after a hearing, impose upon an insurer an administrative fine if he finds that such insurer through the acts of its officers, employees, agents, or representatives has with such frequency as to indicate its general business practice in this state:
  - **(1)** Failed to use due diligence in processing all claims, failed to pay claims in a timely manner, failed to provide proper notice when required with respect to the reasons for the insurer's failure to make claims payments when due, or refused without just cause to pay proper claims arising under coverage provided by its policies, whether the claim is in favor of an insured or in favor of a third person with respect to the liability of an insured to a third person or in favor of any other person entitled to the proceeds of a policy;
  - **(2)** Compelled, without just cause, insureds, claimants, or other persons entitled to the proceeds of its policies in this state to accept less than the amount due them or to bring an action against the insurer or an insured to secure full payment or settlement thereof; or
  - **(3)** Accepted money, trade stamps, gifts, or other remuneration of any kind in return for referring automobile and other property repair business including glass breakage to a particular automobile repairer, glass company, construction company, or other repair company of any kind.
- **(b)** The administrative fine imposed for violations set forth in paragraph (1), (2), or (3) of subsection (a) of this Code section shall not exceed $1,000.00 for each act of misconduct constituting a violation; provided, however, a fine of not more than $5,000.00 for each act of willful misconduct constituting a violation may be imposed.
- **(c)** For the purposes of this Code section, the term "insurer" shall include any insurer, nonprofit organization, or any other person authorized to sell accident and

sickness insurance policies, subscriber contracts, certificates, or agreements of any form under Chapter 15, 20, 21, 29, or 30 of this title.

Amended by 2019 Ga. Laws 139,§ 1-18, eff. 7/1/2019.

2023 CODE OF GEORGIA
Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)
Chapter 3 - AUTHORIZATION AND GENERAL REQUIREMENTS FOR TRANSACTION OF INSURANCE (§§ 33-3-1 — 33-3-30)
Section 33-3-21 - Reports of business affairs and operations of insurers generally

On or before March 1 in each year after it shall have commenced to do business pursuant to a certificate of authority, every insurer shall make and file with the Commissioner a report of its affairs and operations during the year ending on December 31 of the preceding year. This annual report shall be made in such form and contain such information as the Commissioner may prescribe by regulation from time to time and may require in protecting the public interest, the interest of the policyholders of any insurer, and the interest of the investors in the securities issued by any insurer. The Commissioner may require by regulation any additional periodic reports as he or she may prescribe from time to time as necessary or appropriate for the protection of policyholders, investors, and the public and necessary to ensure the solvency of any insurer, to inform and protect the investors in any insurer, and to assure fair dealing in the securities of any insurer. The Commissioner may require that the reports be verified under oath by any appropriate officers or agents as he or she may designate by regulation and may require the same to be published. Compliance with this Code section shall be a condition to the renewal of a certificate of authority under Code Section 33-3-16.

Amended by 2019 Ga. Laws 139,§ 1-19, eff. 7/1/2019.

2023 CODE OF GEORGIA
Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)
Chapter 3 - AUTHORIZATION AND GENERAL REQUIREMENTS FOR TRANSACTION OF INSURANCE (§§ 33-3-1 — 33-3-30)
Section 33-3-21.1 - Submission of reports by property and casualty insurers; types of insurance to which requirement applies; contents of report; public inspection

- **(a)** By rule or regulation, the Commissioner may require each insurer licensed to write property and casualty insurance by the Commissioner to submit a report on a form furnished by the Commissioner showing its direct writings in this state.
- **(b)** The report permitted by subsection (a) of this Code section may include but not be limited to the following types of insurance written by such insurer:
  - **(1)** Motor vehicle bodily injury liability insurance, including medical pay insurance;
  - **(2)** Products liability insurance;
  - **(3)** Medical malpractice insurance;
  - **(4)** Architect and engineer malpractice insurance;

- **(5)** Attorney malpractice insurance;
- **(6)** Motor vehicle personal injury protection insurance;
- **(7)** Motor vehicle property liability insurance;
- **(8)** Uninsured motorist insurance;
- **(9)** Underinsured motorist insurance; and
- **(10)** Commercial casualty or property insurance as defined in paragraph (1) of Code Section 33-7-3 or Code Section 33-7-6.

- **(c)** Additionally, the report shall include the following information:
  - **(1)** Direct premiums written;
  - **(2)** Direct premiums earned;
  - **(3)** Net investment income, including net realized capital gains and losses, using appropriate estimates where necessary;
  - **(4)** Incurred claims, developed as a sum of, and with figures provided for, the following:
    - **(A)** Dollar amount of claims closed with payment; plus
    - **(B)** Reserves for reported claims at the end of the current year; minus
    - **(C)** Reserves for reported claims at the end of the previous year; plus
    - **(D)** Reserves for incurred but not reported claims at the end of the current year; minus
    - **(E)** Reserves for incurred but not reported claims at the end of the previous year; plus
    - **(F)** Reserves for loss adjustment expense at the end of the current year; minus
    - **(G)** Reserves for loss adjustment expense at the end of the previous year;
  - **(5)** Actual incurred expenses allocated separately to loss adjustment, commissions, other acquisition costs, general office expenses, taxes, licenses, fees, and all other expenses;
  - **(6)** Net underwriting gain or loss; and
  - **(7)** Net operation gain or loss, including net investment income.

- **(d)** Any reports provided under this Code section shall be made available to the public for inspection.

Amended by 2014 Ga. Laws 489,§ 1, eff. 7/1/2014.

2023 CODE OF GEORGIA
Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)
Chapter 3 - AUTHORIZATION AND GENERAL REQUIREMENTS FOR TRANSACTION OF INSURANCE (§§ 33-3-1 — 33-3-30)
Section 33-3-21.2 - Analysis of adequacy of loss and loss adjustment expense reserves when reserves outside standard range

- **(a)** As used in this Code section, the term "qualified independent loss reserve specialist" means a person who is not an employee, principal, director, or indirect owner of the insurer and either is a member of the casualty actuarial society or possesses such other experience acceptable to the Commissioner to assure a professional opinion on the adequacy of the loss and loss adjustment expense reserves of the insurer.

- **(b)** Every property and casualty insurer required to file an annual report with the Commissioner which has not filed a statement of opinion relating to loss and loss adjustment expense reserves in connection with its last annual statement on file with the department shall engage, whenever the insurer's loss and loss adjustment expense reserves are outside the standard or average range as designated by the Commissioner and based upon reliable and credible current information, a qualified independent loss reserve specialist to analyze the adequacy of such reserves and file a report with the Commissioner on a date to be specified by the Commissioner.

2023 CODE OF GEORGIA
Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)
Chapter 3 - AUTHORIZATION AND GENERAL REQUIREMENTS FOR TRANSACTION OF INSURANCE (§§ 33-3-1 — 33-3-30)
Section 33-3-21.3 - Annual filings with National Association of Insurance Commissioners; agents of Commissioner not subject to civil liability; confidentiality of information

- **(a)** This Code section shall apply to all domestic, foreign, and alien insurers who are authorized to transact business in this state.

- **(b)**

  - **(1)** Each domestic, foreign, and alien insurer who is authorized to transact insurance in this state shall file annually on or before March 1 of each year with the National Association of Insurance Commissioners a copy of its annual statement convention blank along with such additional filings as prescribed by the Commissioner for the preceding year. The information filed with the National Association of Insurance Commissioners shall be in the same format and scope as that required by the Commissioner and shall include the signed jurat page and the actuarial certification. Any amendments and addendums to the annual statement filing subsequently filed with the Commissioner shall also be filed with the National Association of Insurance Commissioners.

  - **(2)** Foreign insurers that are domiciled in a state which has a law substantially similar to paragraph (1) of this subsection shall be deemed in compliance with this subsection.

- **(c)** In the absence of actual malice, members of the National Association of Insurance Commissioners; their duly authorized committees, subcommittees, and task forces; their delegates; employees of the National Association of Insurance Commissioners; and all others charged with the responsibility of collecting, reviewing, analyzing, and disseminating the information developed from the filing of the annual statement convention blanks shall be acting as agents of the Commissioner under the authority of this Code section and shall not be subject to civil liability for libel, slander, or any other cause of action by virtue of their collection, review, analysis, and dissemination of the data and information collected from the filings required under this Code section.

- **(d)** Notwithstanding any provision of Article 4 of Chapter 18 of Title 50 to the contrary, all financial analysis ratios and examination synopses concerning insurance companies that are submitted to the department with an expectation of confidentiality by the National Association of Insurance Commissioners' Insurance Regulatory Information System shall be confidential and may not be disclosed by the department.

- **(e)** The Commissioner may suspend, revoke, or refuse to renew the certificate of authority of any insurer failing to file its annual statement when due or within any extension of time which the Commissioner, for good cause, may have granted.

2023 CODE OF GEORGIA

Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)

Chapter 3 - AUTHORIZATION AND GENERAL REQUIREMENTS FOR TRANSACTION OF INSURANCE (§§ 33-3-1 — 33-3-30)

Section 33-3-22 - Reports of insurers authorized to transact product liability insurance

The Commissioner by rule and regulation may require each insurer providing product liability insurance in this state to provide reports of its affairs and operations regarding product liability insurance covering risks located in this state with such frequency and in such form as the Commissioner deems necessary.

2023 CODE OF GEORGIA
Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)
Chapter 3 - AUTHORIZATION AND GENERAL REQUIREMENTS FOR TRANSACTION OF INSURANCE (§§ 33-3-1 — 33-3-30)
Section 33-3-23 - Transaction restrictions on lending institutions and bank holding companies

- **(a)** For the purposes of this Code section, the term:
  - **(1)** "Bank holding company" means the definition as set forth in Code Section 7-1-600 and in Section 2 of an act of Congress entitled the Bank Holding Company Act of 1956, as amended.
  - **(2)** "Lending institution" means any domestic institution that accepts deposits from the public and lends money, including banks and savings and loan associations.

- **(b)** A lending institution, bank holding company, or subsidiary or affiliate of either of the foregoing doing business in this state, or any officer or employee of any of the foregoing, may be licensed to sell insurance, including but not limited to credit insurance, in this state and may engage in underwriting and act as an underwriter for credit life insurance and credit accident and sickness insurance subject to the provisions of this title and in conformity with rules and regulations promulgated by the Commissioner.

- **(c)** Nothing in this chapter shall prohibit the purchase of mortgage guaranty insurance, also called credit loss insurance, by a lending institution from a mortgage guaranty insurance company directly or indirectly.

- **(d)** No lending institution, bank holding company, or any subsidiary or affiliate of any of the foregoing doing business in this state that was not in the business of selling title insurance on or before April 1, 2000, shall be permitted to sell title insurance.

Amended by 2019 Ga. Laws 139,§ 1-20, eff. 7/1/2019.

2023 CODE OF GEORGIA
Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)
Chapter 3 - AUTHORIZATION AND GENERAL REQUIREMENTS FOR TRANSACTION OF INSURANCE (§§ 33-3-1 — 33-3-30)
Section 33-3-24 - Transaction restrictions on institutions of Farm Credit System

- **(a)** No institution included in the Farm Credit System as set forth and identified in 12 U.S.C.A., Section 2002 (Pub. Law 92-181, Sec. 1.2, Dec. 10, 1971, 85 Stat. 583), any subsidiary or affiliate of such institution doing business in this state, any officer or employee of any institution included in the Farm Credit System, or any subsidiary or affiliate of any institution may directly or indirectly be licensed to sell or solicit any type of insurance, except the following:

  - **(1)** Credit life and accident and health in an amount appropriate to insure repayment of the loan;

  - **(2)** Crop hail, hail, or wind damage to crops; or

  - **(3)** Insurance against loss of any collateral securing a loan extended by an affiliate bank or association of the Farm Credit System for the full value of such collateral. The right to place collateral insurance, however, shall continue only so long as the underlying loan remains outstanding or until the expiration of the policy, but in no event longer than 12 months from the last day the loan was outstanding.

- **(b)** For purposes of this Code section, "collateral securing a loan" shall include only that property which is subject to the formal security interest granted in connection with the secured loan and duly filed and recorded in the county where the debtor resides; provided, however, "collateral securing a loan" shall not include any property acquired by the debtor after the date the underlying loan was made unless the secured party shall make an advance to the debtor or otherwise give new value which is to be secured in whole or in part by after-acquired property.

- **(c)** For the purposes of this Code section, institutions constituting the Farm Credit System shall include the federal land banks, the federal land bank associations, the

federal intermediate credit banks, the production credit associations, the banks for cooperatives, and such other institutions as may be made part of the system, all of which are chartered by and subject to the supervision of the Farm Credit Administration; provided, however, that the types of insurance described in paragraphs (1), (2), and (3) of subsection (a) of this Code section may only be transacted, sold, or solicited for the purposes of protecting loans made for agricultural purposes to farmers by an institution of the Farm Credit System or any subsidiary or affiliate thereof doing business in this state.

- **(d)** Any person holding a license to sell or solicit insurance on April 8, 1977, and disqualified under the terms of subsection (a) of this Code section upon termination of his association as an employee or officer, or both, of any Farm Credit System institution or affiliate or subsidiary thereof shall have his license reissued upon request without the necessity of taking or passing any examination. Applications shall be made within 60 days from the date of termination of such employment.

2023 CODE OF GEORGIA
Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)
Chapter 3 - AUTHORIZATION AND GENERAL REQUIREMENTS FOR TRANSACTION OF INSURANCE (§§ 33-3-1 — 33-3-30)
Section 33-3-25 - Language simplification and reading ease standards; applicability of Code section

- **(a)** All homeowner's insurance policies, including tenant homeowner's insurance policies, personal automobile insurance policies, individual life or accident and sickness insurance policies, all certificates of group life or accident and sickness insurance coverage, and all coverage booklets provided by insurers to group life or accident and sickness insurance certificate holders which are issued, delivered, or issued for delivery in this state on or after July 1, 1988, shall be written in a simplified form, shall be divided into logically arranged, captioned sections, and shall contain readable language which complies with the standards prescribed in such rules and regulations as may be promulgated by the Commissioner after due notice and hearing.

- **(b)** In establishing the policy language simplification and reading ease standards for such policies, certificates, and coverage booklets, the Commissioner may utilize a minimum score of 40 on the "Flesch reading ease test" as the basic standard, or such other nationally recognized reading ease standards or tests as would produce comparable policy language simplification and readability results, and may also provide for exceptions thereto by appropriate rules and regulations.

- **(c)** This Code section shall apply to all insurers issuing the kinds of insurance policies described in subsection (a) of this Code section in this state, including all insurers, nonprofit corporations, or other organizations issuing policies or contracts of life or accident and sickness coverage under Chapter 15, 20, 21, 29, or 30 of this title.

Amended by 2019 Ga. Laws 139,§ 1-21, eff. 7/1/2019.

2023 CODE OF GEORGIA
Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)
Chapter 3 - AUTHORIZATION AND GENERAL REQUIREMENTS FOR

TRANSACTION OF INSURANCE (§§ 33-3-1 — 33-3-30)
Section 33-3-26 - Retaliation

- **(a)** When by or pursuant to the laws of any other state or foreign country any taxes, licenses, and other fees in the aggregate and any fines, penalties, deposit requirements, or other material obligations, prohibitions, or restrictions are or would be imposed upon Georgia insurers or upon the agents or representatives of such insurers which are in excess of such taxes, licenses, and other fees in the aggregate or which are in excess of the fines, penalties, deposit requirements, or other obligations, prohibitions, or restrictions directly imposed upon similar insurers or upon the agents or representatives of such insurers of such other state or country under the statutes of this state, so long as such laws of such other state or country continue in force or are so applied, the same taxes, licenses, and other fees in the aggregate or fines, penalties, deposit requirements, or other material obligations, prohibitions, or restrictions of whatever kind shall be imposed by the Commissioner upon the insurers or upon the agents or representatives of such insurers of such other state or country doing business or seeking to do business in Georgia. Any tax, license, or other fee or other obligation imposed by any city, county, or other political subdivision or agency of such other state or country on Georgia insurers or their agents or representatives shall be deemed to be imposed by such state or country within the meaning of this Code section.

- **(b)** The Commissioner may waive any retaliatory obligations, prohibitions, or restrictions that would prohibit entry into this state of any insurer domiciled in another state and that would otherwise be imposed by subsection (a) of this Code section if, in his or her discretion, the entry of such insurer would be expected to enhance competition in this state and would be in the best interests of the citizens of this state. The discretion provided by this subsection shall not extend to any retaliatory taxes, fees, fines, penalties, or deposit requirements.

- **(c)** This Code section shall not apply as to personal income taxes, as to ad valorem taxes on real or personal property, or as to special purpose obligations or assessments imposed by another state in connection with particular kinds of insurance other than property insurance, except that deductions from premium taxes or other taxes otherwise payable allowed on account of real estate or personal property taxes paid shall be taken into consideration by the Commissioner in determining the propriety and extent of retaliatory action under this Code section.

- **(d)** For the purposes of this Code section, the domicile of an alien insurer other than insurers formed under the laws of Canada shall be that state designated by the insurer in writing filed with the Commissioner at the time of admission to this state and may be any one of the following states:

    - **(1)** This state if the insurer is entering through this state to transact insurance in the United States through a United States branch;

    - **(2)** That in which the insurer was first authorized to transact insurance;

    - **(3)** That in which is located the insurer's principal place of business in the United States; or

- **(4)** That in which is held the larger deposit of trusteed assets of the insurer for the protection of its policyholders and creditors in the United States.

- **(e)** If the insurer makes no such designation, its domicile shall be deemed to be that state in which is located its principal place of business in the United States.

- **(f)** In the case of an insurer formed under the laws of Canada or a province thereof, its domicile shall be deemed to be that province in which its head office is situated.

Amended by 2008 Ga. Laws 537,§ 1, eff. 7/1/2008.

2023 CODE OF GEORGIA
Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)
Chapter 3 - AUTHORIZATION AND GENERAL REQUIREMENTS FOR TRANSACTION OF INSURANCE (§§ 33-3-1 — 33-3-30)
Section 33-3-27 - Reports of awards under medical malpractice insurance policies

- **(a)** For the purposes of this Code section, the term:

- **(1)** "High/low agreement" means a settlement in which a defendant agrees to pay the plaintiff a minimum recovery in return for the plaintiff's agreement to accept a maximum amount regardless of the outcome of the trial.

- **(2)** "Low payment" means the defendant pays the plaintiff the minimum recovery under a high/low agreement where the court rules in favor of the defendant.

- **(3)** "Medical malpractice claim" means any claim for damages resulting from the death of or injury to any person arising out of health, medical, or surgical service, diagnosis, prescription, treatment, or care rendered by a person authorized by law to practice medicine in this state or by any person acting under such person's supervision and control.

- **(b)** Every insurer providing medical malpractice insurance coverage in this state shall notify in writing the Georgia Composite Medical Board when it pays a judgment or enters into an agreement to pay an amount to settle a medical malpractice claim, other than a low payment under a high/low agreement, against a person authorized by law to practice medicine in this state. Such judgments or agreements shall be reported to the board regardless of the dollar amount. Such notice shall be sent within 30 days after the judgment has been paid or the agreement has been entered into by the parties involved in the claim.

Amended by 2019 Ga. Laws 269,§ 1, eff. 7/1/2019.

Amended by 2009 Ga. Laws 243,§ 2, eff. 7/1/2009.

Amended by 2005 Ga. Laws 1,§ 8, eff. 2/16/2005.

2023 CODE OF GEORGIA
Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)
Chapter 3 - AUTHORIZATION AND GENERAL REQUIREMENTS FOR TRANSACTION OF INSURANCE (§§ 33-3-1 — 33-3-30)
Section 33-3-28 - Request by claimant for information as to name of insurer, name of each insured, and limits of coverage

- **(a)**
  - **(1)** Every insurer providing liability or casualty insurance coverage in this state and which is or may be liable to pay all or a part of any claim shall provide, within 60 days of receiving a written request from the claimant, a statement, under oath, of a corporate officer or the insurer's claims manager stating with regard to each known policy of insurance issued by it, including excess or umbrella insurance, the name of the insurer, the name of each insured, and the limits of coverage. Such insurer may provide a copy of the declaration page of each such policy in lieu of providing such information. The claimant's request shall set forth under oath the specific nature of the claim asserted and shall be mailed to the insurer by certified mail or statutory overnight delivery.
  - **(2)** The insured, within 30 days of receiving a written request from a claimant or the claimant's attorney, shall disclose to the claimant or his attorney the name of each known insurer which may be liable to the claimant upon such claim.
- **(b)** If the request provided in subsection (a) of this Code section contains information insufficient to allow compliance, the insurer or insured upon whom the request was made may so state in writing, stating specifically what additional information is needed, and such compliance shall constitute compliance with this Code section.
- **(c)** The information provided to a claimant or his attorney as required by subsection (a) of this Code section shall not create a waiver of any defenses to coverage available to the insurer and shall not be admissible in evidence unless otherwise admissible under Georgia law.
- **(d)** The information provided to a claimant or his attorney as required by subsection (a) of this Code section shall be amended upon the discovery of facts inconsistent with or in addition to the information provided.

2023 CODE OF GEORGIA
Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)
Chapter 3 - AUTHORIZATION AND GENERAL REQUIREMENTS FOR TRANSACTION OF INSURANCE (§§ 33-3-1 — 33-3-30)
Section 33-3-29 - Licensing of foreign state insurers as domestic insurers

- **(a)** Any insurer which is organized under the laws of any other state and is admitted to do business in this state for the purpose of writing insurance may become a domestic insurer by complying with all of the requirements of this title relative to the organization and licensing of a domestic insurer of the same type and by designating its principal place of business at a location in this state. Upon satisfaction of such requirements, the insurer shall be issued a certificate of authority and license to transact business in this state and shall be subject to the authority and jurisdiction of this state as a domestic insurer. The redomesticated insurer may choose to retain its original date of incorporation in lieu of its date of redomestication, provided that the retention of an earlier incorporation date shall not affect the operation or application of other laws.
- **(b)** Any domestic insurer may, upon the approval of the Commissioner, transfer its domicile to any other state in which it is admitted to transact the business of

insurance and, upon such a transfer, shall cease to be a domestic insurer and shall be admitted to this state if qualified as a foreign insurer. The Commissioner shall approve any such proposed transfer unless the Commissioner determines such transfer is not in the best interest of the policyholders of this state.

- **(c)** The certificate of authority, agent appointments and licenses, rates, and other items which the Commissioner allows, in his discretion, and which are in existence at the time any insurer licensed to transact the business of insurance in this state transfers its corporate domicile to this or any other state by merger, consolidation, or any other lawful method shall continue in full force and effect upon such transfer if such insurer remains duly authorized to transact the business of insurance in this state. All outstanding policies of any transferring insurer shall remain in full force and effect and need not be endorsed as to the new name of the company or its new location unless so ordered by the Commissioner. Every transferring insurer shall file new policy forms with the Commissioner on or before the effective date of the transfer but may use existing policy forms with appropriate endorsements if allowed by, and under such conditions as approved by, the Commissioner. Every such transferring insurer shall notify the Commissioner of the details of the proposed transfer and shall file promptly any forms, documents, or amendments to forms or documents with the Commissioner. The Commissioner may promulgate rules and regulations necessary to carry out the purposes of this Code section.

2023 CODE OF GEORGIA
Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)
Chapter 3 - AUTHORIZATION AND GENERAL REQUIREMENTS FOR TRANSACTION OF INSURANCE (§§ 33-3-1 — 33-3-30)
Section 33-3-30 - Principal United States place of business of alien insurer entering through this state

- **(a)** Each alien insurer which enters through this state to transact insurance in the United States through a United States branch shall establish and maintain in this state such insurer's principal place of business in the United States, and shall keep in such principal place of business complete records of the assets, transactions, and affairs in accordance with the methods and systems which are customary or suitable as to the kind or kinds of insurance transacted in the United States.

- **(b)** Concealment from the Commissioner or removal from this state of any material part of the records required to be kept in this state under subsection (a) of this Code section, except for any reasonable purposes and periods of time as may be approved by the Commissioner in writing in advance of such removal, is prohibited. The certificate of authority to do business of any alien insurer which removes or attempts to remove any material part of such records from the principal place of business of the insurer in this state with the intent to remove the same from this state or conceals or attempts to conceal the same from the Commissioner in violation of this subsection shall be revoked. Upon any removal or attempted removal of such records or upon retention of such records or material part of such records outside this state beyond the period specified in the Commissioner's consent under which such records were permitted to be removed or upon concealment of or attempts to conceal such records in

violation of this subsection, the Commissioner may institute proceedings against the insurer pursuant to Chapter 37 of this title.

- **(c)** This Code section shall not be deemed to prohibit or prevent an alien insurer from establishing and maintaining branch offices or regional home offices in other states where necessary or convenient to the transaction of its business and keeping therein the detailed records customary and necessary for the servicing of the insurance in force in the jurisdiction served by such an office as long as such records are made readily available at such office for examination by the Commissioner at his request.

Georgia Code § 33-1-2

2023 CODE OF GEORGIA
Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)
Chapter 1 - GENERAL PROVISIONS (§§ 33-1-1 — 33-1-27)
Section 33-1-9 - Insurance fraud; venue; penalty; exemption

- **(a)** Any natural person who knowingly or willfully:
  - **(1)** Makes or aids in the making of any false or fraudulent statement or representation of any material fact or thing:
    - **(A)** In any written statement or certificate;
    - **(B)** In the filing of a claim;
    - **(C)** In the making of an application for a policy of insurance;
    - **(D)** In the receiving of such an application for a policy of insurance; or
    - **(E)** In the receiving of money for such application for a policy of insurance

  for the purpose of procuring or attempting to procure the payment of any false or fraudulent claim or other benefit by an insurer;
  - **(2)** Receives money for the purpose of purchasing insurance and converts such money to such person's own benefit;
  - **(3)** Issues fake or counterfeit insurance policies, certificates of insurance, insurance identification cards, or insurance binders; or
  - **(4)** Makes any false or fraudulent representation as to the death or disability of a policy or certificate holder in any written statement or certificate for the purpose of fraudulently obtaining money or benefit from an insurer

  commits the crime of insurance fraud.
- **(b)** Any natural person who knowingly and willfully or with reckless disregard engages in the following activities, either directly or indirectly, as an agent for, as a representative of, or on behalf of an insurer not authorized to transact insurance in this state commits the crime of insurance fraud:
  - **(1)** Soliciting, negotiating, procuring, or effectuating insurance or annuity contracts or renewals thereof;

- **(2)** Soliciting, negotiating, procuring, or effectuating any contract relating to benefits or services;
- **(3)** Disseminating information as to coverage or rates;
- **(4)** Forwarding applications;
- **(5)** Delivering policies or contracts;
- **(6)** Inspecting or assessing risk;
- **(7)** Fixing of rates;
- **(8)** Investigating or adjusting claims or losses;
- **(9)** Collecting or forwarding of premiums; or
- **(10)** In any other manner representing or assisting such an insurer in the transaction of insurance with respect to subjects of insurance resident, located, or to be performed in this state.

- **(c)** Any natural person who knowingly and willfully with intent to defraud subscribes, makes, or concurs in making any annual or other statement required by law to be filed with the Commissioner containing any material statement which is false commits the crime of insurance fraud.
- **(d)** In any prosecution under this Code section, the crime shall be considered as having been committed in the county of the purported loss, in the county in which the insurer or the insurer's agent received the fraudulent or false claim or application, in the county in which money was received for the fraudulent application, or in any county where any act in furtherance of the criminal scheme was committed.
- **(e)** A natural person convicted of a violation of this Code section shall be guilty of a felony and shall be punished by imprisonment for not less than two nor more than ten years, or by a fine of not more than $10,000.00, or both.
- **(f)** Subsection (b) of this Code section shall not apply to a contract of insurance entered into in accordance with Article 2 of Chapter 5 of this title.

Amended by 2004 Ga. Laws 583, § 1A, eff. 5/13/2004.

Amended by 2003 Ga. Laws 276, § 1, eff. 6/3/2003.

Amended by 2003 Ga. Laws 97, § 1.2, eff. 5/30/2003.

Georgia Code Title 33, Chapter 23

2023 CODE OF GEORGIA
Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)
Chapter 23 - LICENSING OF AGENTS, AGENCIES, SUBAGENTS, COUNSELORS, AND ADJUSTERS (§§ 33-23-1 — 33-23-205)

Article 1 - AGENTS, AGENCIES, SUBAGENTS, COUNSELORS, AND ADJUSTERS (§§ 33-23-1 — 33-23-46)

Section 33-23-1 - Definitions

2023 CODE OF GEORGIA
Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)
Chapter 23 - LICENSING OF AGENTS, AGENCIES, SUBAGENTS, COUNSELORS, AND ADJUSTERS (§§ 33-23-1 — 33-23-205)
Article 1 - AGENTS, AGENCIES, SUBAGENTS, COUNSELORS, AND ADJUSTERS (§§ 33-23-1 — 33-23-46)
Section 33-23-1 - Definitions

(a) As used in this article, the term:

(1) "Adjuster" means any individual who for a fee, commission, salary, or other compensation investigates, settles, or adjusts and reports to his or her employer or principal with respect to claims arising under insurance contracts on behalf of the insurer or the insured or a person who directly supervises or manages such individual. The term "adjuster" does not include:

(A) Individuals who adjust claims arising under contracts of life or marine insurance or annuities; or

(B) An agent or a salaried employee of an agent or a salaried employee of an insurer who adjusts or assists in adjusting losses under policies issued by such agent or insurer.

(2) "Agency" means a business entity which represents one or more insurers and is engaged in the business of selling, soliciting, or negotiating insurance. Agency also means a business entity insurance producer.

(3) "Agent" means an individual appointed or employed by an insurer who sells, solicits, or negotiates insurance. Agent also means an individual insurance producer.

(3.1) "Automated claims adjudication system" means a preprogrammed computer system designed for the collection, data entry, calculation, and final resolution of property insurance claims used only for portable electronics as defined in paragraph (1) of subsection (d) of Code Section 33-23-12 which:

(A) May only be utilized by a licensed independent adjuster, licensed agent, or supervised individuals operating pursuant to this paragraph;

(B) Shall comply with all claims payment requirements of the Georgia Insurance Code; and

(C) Shall be certified as compliant with this Code section by a licensed independent adjuster that is an officer of a business entity licensed under this chapter.

(4) "Business entity" means a corporation, association, partnership, sole proprietorship, limited liability company, limited liability partnership, or other legal entity.

(5) "Controlled business of a person" means property or casualty insurance for a person or a person's spouse; for any relative by blood or marriage within the second degree of kinship as defined by paragraph (5) of Code Section 53-4-2; for a person's employer or the firm of which a person is a member; for any officer, director, stockholder, or member of a person's employer or of any firm of which a person is a partner; for any spouse of the officer, director, employer, stockholder, or member of a person's firm; for a person's ward or employee; or for any person or in regard to any property under a person's control or supervision in any fiduciary capacity.

(6) "Counselor" means any individual who engages or advertises or holds himself or herself out as engaging in the business of counseling, advising, or rendering opinions as to the benefits promised under any contract of insurance issued or offered by any insurer or as to the terms, value, effect, advantages, or disadvantages under the contract of insurance, other than an actuary or consultant advising insurers. When receiving a fee, commission, or other compensation for this service, such individual shall not receive any compensation from any other source on or relating to the same transaction.

(7) "Home state" means Canada, the District of Columbia, and any state or territory of the United States in which an insurance producer or adjuster maintains his or her principal place of residence or principal place of business and is licensed to act as an insurance producer or adjuster.

(8) "Independent adjuster" means an adjuster representing the interest of the insurer who is not an employee of such insurer.

(9) "Insurance," except where the type of insurance is specifically stated, means all kinds of insurance other than bail bonding by individual sureties.

(10) "Insurance producer" means a person required to be licensed under the laws of this state to sell, solicit, or negotiate insurance.

(10.1) "Limited subagent" means an individual licensed on behalf of a licensed agent pursuant to Code Section 33-23-12.

(11) "Negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms, or conditions of the contract,

provided that the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers.

(12) "Person" means an individual or business entity.

(13) "Public adjuster" means any person who solicits, advertises for, or otherwise agrees to represent only a person who is insured under a policy covering fire, windstorm, water damage, and other physical damage to real and personal property other than vehicles licensed for the road, and any such representation shall be limited to the settlement of a claim or claims under the policy for damages to real and personal property, including related loss of income and living expense losses but excluding claims arising out of any motor vehicle accident, and who, for compensation on behalf of an insured:

(A) Acts or aids, solely in relation to first-party claims arising under insurance contracts that insure the real or personal property of the insured, in negotiating for, or effecting the settlement of, a claim for loss or damage covered by an insurance contract;

(B) Advertises for employment as a public adjuster of insurance claims or solicits business or represents himself or herself to the public as a public adjuster of first-party claims for losses or damages arising out of policies of insurance that insure real or personal property; or

(C) Directly or indirectly solicits business, investigates or adjusts losses, or advises an insured about first-party claims for losses or damages arising out of policies of insurance that insure real or personal property for another person engaged in the business of adjusting losses or damages covered by an insurance policy.

(14) "Sell" means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurance company.

(15) "Solicit" means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular company.

(16) "Subagent" means any licensed agent, except as provided in Code Section 33-23-12, who acts for or on behalf of another licensed agent in the selling of, solicitation of, or negotiation for an insurance contract or annuity contract and who has on file with the Commissioner a certificate of authority from each agent with whom the subagent places insurance. Subagent also means subproducer. The term "subagent" shall not include:

(A) An agent who places insurance with or through another agent involving 12 or fewer policies or certificates of insurance in any one calendar year; or

(B) An agent who places surplus lines insurance with or through a surplus lines broker only with respect to such surplus lines insurance.

(17) "Surplus lines broker" means an individual licensed pursuant to Code Section 33-23-37.

(b) The definitions of agent, subagent, and counselor in subsection (a) of this Code section shall not be deemed to include:

(1) An attorney at law admitted to practice in this state, when handling the collections of premiums or advising clients as to insurance as a function incidental to the practice of law or who adjusts losses which are incidental to the practice of his or her profession;

(2) Any representative of ocean marine insurers;

(3) Any representative of farmers' mutual fire insurance companies as defined in Chapter 16 of this title;

(4) A salaried employee of a credit or character reporting firm or agency not engaged in the insurance business who may, however, report to an insurer;

(5) A person acting for or as a collection agency;

(6) A person who makes the salary deductions of premiums for employees or, under a group insurance plan, a person who serves the master policyholder of group insurance in administering the details of such insurance for the employees or debtors of the master policyholder or of a firm or corporation by which the person is employed and who does not receive insurance commissions for such service; provided, further, that an administration fee not exceeding 5 percent of the premiums collected paid by the insurer to the administration office shall not be construed to be an insurance commission;

(7) Persons exempted from licensure as provided in subsection (h) of Code Section 33-23-4; or

(8) An individual who collects claim information from, or furnishes claim information to, insureds or claimants, who conducts data entry, and who enters data into an automated claims adjudication system, provided that the individual is an employee of a licensed independent adjuster or its affiliate where no more than 25 such persons are under the supervision of one licensed independent adjustor or licensed agent.

(c) In addition to paragraphs (2) through (8) of subsection (b) of this Code section, the definitions of public adjuster, independent adjuster, and adjuster in subsection

(a) of this Code section shall not be deemed to include an attorney admitted to practice law in this state.

Amended by 2014 Ga. Laws 504,§ 1 and § 2, eff. 7/1/2014.

Amended by 2012 Ga. Laws 776,§ 5, eff. 7/1/2012.

Amended by 2012 Ga. Laws 776,§ 4, eff. 7/1/2012.

Amended by 2012 Ga. Laws 776,§ 3, eff. 7/1/2012.

Amended by 2012 Ga. Laws 727,§ 6, eff. 7/1/2012.

Amended by 2012 Ga. Laws 727,§ 5, eff. 7/1/2012.

Amended by 2012 Ga. Laws 727,§ 4, eff. 7/1/2012.

Amended by 2008 Ga. Laws 767,§ 1, eff. 7/1/2008.

Amended by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-1.1 - Counselor's additional ancillary services considered a separate transaction

As used in paragraph (6) of subsection (a) of Code Section 33-23-1, the definition of counselor, the term "transaction" refers to coverage or services in the same line or subline of insurance; provided, however, that additional ancillary services for commercial risks in excess of acquisition services shall be considered a separate transaction when such additional ancillary services are disclosed in writing to the insured and approved in advance by the insured. Additional ancillary services shall include, but not be limited to, the following: risk identification; loss measurement; gathering and analysis of loss information; verification of workers' compensation experience modifiers; setting of risk retention levels; development of retention financing plans; development of insurance specifications; negotiation with insurers regarding coverages, costs, and payment options; implementation of retained and transferred risk programs; monitoring of annual program; and insurance audit services.

Amended by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-2 - [Repealed] Licenses to be issued only to individuals

Repealed and reserved by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-3 - Agency licensing and biennial renewals; ownership restrictions

(a) Each principal office and each branch office of an agency as defined in paragraph (2) of subsection (a) of Code Section 33-23-1 must obtain an agency license prior to commencement of operations and renew such license biennially

and prior to December 31 by filing application forms prescribed by the Commissioner.

(b) An agency shall be subject to all penalties, fines, criminal sanctions, and other actions authorized for agents under this title.

(c) No person shall be an owner of an agency or, if the agency is a corporation, no person shall be an officer or director of such corporation or own 10 percent or more of the corporation if such person has had his or her license under this title refused, revoked, or suspended.

Amended by 2019 Ga. Laws 140,§ 4, eff. 7/1/2019.

Amended by 2012 Ga. Laws 419,§ 1, eff. 3/22/2012.

Amended by 2011 Ga. Laws 220,§ 2, eff. 5/12/2011.

Amended by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-4 - License required; restrictions on payment or receipt of commissions; positions indirectly related to sale, solicitation, or negotiation of insurance excluded from licensing requirements

(a)

(1) A person shall not sell, solicit, or negotiate insurance in this state for any class or classes of insurance unless such person is licensed for that line of authority in accordance with this article and applicable regulations.

(2) Any individual who sells, solicits, or negotiates insurance in this state shall be licensed as an agent.

(3) Any business entity that sells, solicits, or negotiates insurance in this state shall be licensed as an agency.

(4) Any individual defined as an adjuster under paragraph (1) of subsection (a) of Code Section 33-23-1 who for a fee, commission, salary, or other compensation investigates, settles, or adjusts claims arising under insurance contracts on behalf of the insurer or the insured shall be licensed as either an independent adjuster or a public adjuster.

(b) No insurer or agent doing business in this state shall pay, directly or indirectly, any commissions or any other valuable consideration to any person for services as an agent, subagent, or adjuster within this state, unless such person is duly licensed in accordance with this article.

(c) An insurer may pay a commission or other valuable consideration to a licensed insurance agency in which all employees, stockholders, directors, or officers who

sell, solicit, or negotiate insurance contracts are qualified insurance agents, limited subagents, or counselors holding valid licenses as required by the laws of this state; and an agent, limited subagent, or counselor may share any commission or other valuable consideration with such a licensed insurance agency.

(d) No person other than a duly licensed adjuster, agent, limited subagent, or counselor shall pay or accept any commission or other valuable consideration except as provided in subsections (b) and (c) of this Code section.

(e) This Code section shall not prevent the payment or receipt of renewal or deferred commissions by any agency or a person on the grounds that the licensee has ceased to be an agent, limited subagent, or counselor nor prevent the receipt or payment of any commission by an individual who has been issued a temporary license pursuant to this chapter.

(f) Any individual who has been licensed as an agent for ten consecutive years or more and who does not perform any of the functions specified in paragraph (3) of subsection (a) of Code Section 33-23-1 other than receipt of renewal or deferred commissions shall be exempt from the requirement to maintain at least one certificate of authority; provided, however, that if such individual wishes to again perform any of the other functions specified in said paragraph, such individual must obtain approval from the Commissioner and comply with the requirements of this article and applicable rules and regulations, including without limitation the requirements for certificate of authority.

(g) Any person who willfully violates this Code section shall be guilty of a misdemeanor and, upon conviction thereof, shall be subject to punishment as provided in Code Section 17-10-3, relating to punishment for misdemeanors.

(h)

(1) Nothing in this article shall be construed to require an insurer to obtain an insurance agent's license. As used in this Code section, the term "insurer" does not include an insurer's officers, directors, employees, subsidiaries, or affiliates.

(2) A license as an insurance agent shall not be required of the following:

(A) An officer, director, or employee of an insurer or of an insurance agent or agency, provided that the officer, director, or employee does not receive any commission on policies written or sold to insure risks residing, located, or to be performed in this state and:

(i) The officer, director, or employee's activities are executive, administrative, managerial, clerical, or a combination of these, and are only indirectly related to the sale, solicitation, or negotiation of insurance;

(ii) The officer, director, or employee's function relates to underwriting, loss control, inspection, or the processing, adjusting, investigating, or settling of a claim on a contract of insurance; or

(iii) The officer, director, or employee is acting in the capacity of a special agent or agency supervisor assisting insurance agents where the person's activities are limited to providing technical advice and assistance to licensed insurance producers and do not include the sale, solicitation, or negotiation of insurance;

(B) A person who meets the criteria set forth in paragraph (1), (4), or (6) of subsection (b) of Code Section 33-23-1;

(C) An employer or association or its officers, directors, or employees or the trustees of an employee trust plan to the extent that the employers, officers, employees, directors, or trustees are engaged in the administration or operation of a program of employee benefits for the employer's or association's own employees or the employees of its subsidiaries or affiliates, which program involves the use of insurance issued by an insurer, so long as the employers, associations, officers, directors, employees, or trustees are not in any manner compensated, directly or indirectly, by the company issuing the contracts;

(D) Employees of insurers or organizations employed by insurers who are engaging in the inspection, rating, or classification of risks or in the supervision of the training of insurance agents and who are not individually engaged in the sale, solicitation, or negotiation of insurance;

(E) A person whose activities in this state are limited to advertising without the intent to solicit insurance in this state through communications in printed publications or other forms of electronic mass media whose distribution is not limited to residents of the state, provided that the person does not sell, solicit, or negotiate insurance that would insure risks residing, located, or to be performed in this state;

(F) A person who is not a resident of this state who sells, solicits, or negotiates a contract of insurance for commercial property and casualty risks to an insured with risks located in more than one state insured under that contract, provided that the person is otherwise licensed as an insurance agent to sell, solicit, or negotiate insurance in the state where the insured maintains its principal place of business and the contract of insurance insures risks located in that state; or

(G) A salaried, full-time employee who counsels or advises his or her employer relative to the insurance interests of the employer or of the subsidiaries or business affiliates of the employer provided that the employee does not sell or solicit insurance or receive a commission.

Amended by 2019 Ga. Laws 140,§ 5, eff. 7/1/2019.

Amended by 2017 Ga. Laws 275,§ 33, eff. 5/9/2017.

Amended by 2016 Ga. Laws 374,§ 1, eff. 7/1/2016.

Amended by 2014 Ga. Laws 504,§ 3, eff. 7/1/2014.

Amended by 2008 Ga. Laws 767,§ 2, eff. 7/1/2008.

Amended by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-5 - Qualifications and requirements for license

(a) For the protection of the people of this state, the Commissioner shall not issue, continue, or permit to exist any license, except in compliance with this chapter and except as provided in Code Sections 33-23-3, 33-23-4, 33-23-12, 33-23-13, 33-23-14, 33-23-16, 33-23-17, 33-23-29, 33-23-29.1, and 33-23-37. The Commissioner shall not issue a license to any individual applicant for a license who does not meet or conform to qualifications or requirements set forth in paragraphs (1) through (7) of this subsection:

(1) The individual applicant shall be a resident of this state who shall reside and be present within this state for at least six months of every year or an individual whose principal place of business is within this state; provided, however, that in cities, towns, or trade areas, either unincorporated or composed of two or more incorporated cities or towns, located partly within and partly outside this state, requirements as to residence and principal place of business shall be deemed met if the residence or place of business is located in any part of the city, town, or trade area and if the other state in which the city, town, or trade area is located in part has established like requirements as to residence and place of business. The individual applying for an agent, adjuster, or counselor license shall be at least 18 years of age;

(2) If applying for an agent's license for property and casualty insurance, the applicant shall not use or intend to use such license for the purpose of obtaining a rebate or commission upon controlled business; and the applicant shall not in any calendar year effect controlled business that will aggregate as much as 25 percent of the volume of insurance effected by such applicant during such year, as measured by the comparative amounts of premiums;

(3) The individual applicant shall be of good character;

(4) The individual applicant shall pass any written examination required for the license by this article, provided that:

(A) An individual who applies for an insurance agent's license in this state who was previously licensed for the same lines of authority in another state shall not be required to complete any prelicensing education or examination. This exemption shall only be available if the individual is currently licensed in that state or if the application is received within 90 days of the cancellation of the applicant's previous license and if the prior state issues a certification that, at the time of cancellation, the applicant was in good standing in that state or the state's producer data base records maintained by the National Association of Insurance Commissioners, its affiliates, or subsidiaries indicate that the agent is or was licensed in good standing for the line of authority requested; and

(B) An individual licensed as an insurance agent in another state who moves to this state shall make application within 90 days of establishing legal residence to become a resident licensee pursuant to Code Section 33-23-8. No prelicensing education or examination shall be required of that individual to obtain a license for any line of authority previously held in the prior state except where the Commissioner determines otherwise by rule or regulation;

(5) If applying for a license as counselor, the applicant shall show that he or she either has had five years' experience as an agent, subagent, or adjuster or in some other phase of the insurance business or has sufficient teaching or educational qualifications or experience which, in the opinion of the Commissioner, has qualified the applicant to act as such counselor; and the applicant shall pass such examination as shall be required by the Commissioner unless such applicant is exempted by the Commissioner, based on the applicant's experience and qualifications and pursuant to a regulation adopted by the Commissioner;

(6) If applying for an agent's license, limited subagent's license, or adjuster's license, no applicant shall be qualified therefor or be so licensed unless he or she has successfully completed classroom courses in insurance satisfactory to the Commissioner at a school which has been approved by the Commissioner; and

(7) The Commissioner shall by rule or regulation establish criteria and procedures for the scope of prelicensing requirements and exemptions, if any, to the prelicensing or examination requirements.

(b) An individual who was licensed as an agent, counselor, limited subagent, surplus line broker, or adjuster at the time such individual was employed by the Commissioner and who while so employed was employed in responsible insurance duties as a full-time bona fide employee shall be permitted to reinstate his or her license upon termination of employment if written request is made within 90 days after the date of termination of employment with the Commissioner.

(c) Active licensees who apply for additional licenses and individuals who apply for the reinstatement of a license prior to six months from the license expiration date shall not be required to submit fingerprints pursuant to Code Section 33-23-5.1.

(d) Notwithstanding paragraph (1) of subsection (a) of this Code section, no resident of Canada may be licensed as an independent adjuster pursuant to this Code section or designate Georgia as his or her home state unless such person has successfully passed the adjuster examination and has complied with other applicable portions of this Code section.

Amended by 2012 Ga. Laws 776,§ 6, eff. 7/1/2012.

Amended by 2012 Ga. Laws 727,§ 7, eff. 7/1/2012.

Amended by 2009 Ga. Laws 107,§ 1, eff. 7/1/2009.

Amended by 2008 Ga. Laws 767,§ 3, eff. 7/1/2008.

Amended by 2006 Ga. Laws 667,§ 7, eff. 7/1/2006.

Amended by 2005 Ga. Laws 19,§ 33, eff. 4/7/2005.

Amended by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Amended by 2001 Ga. Laws 2, § 33, eff. 2/12/2001.

Section 33-23-5.1 - Conviction data

(a) As used in this Code section, the term "conviction data" means a record of a finding or verdict of guilty or plea of guilty or nolo contendere with regard to any crime regardless of whether an appeal of the conviction has been sought.

(b) With respect to the requirements of paragraph (3) of subsection (a) of Code Section 33-23-5, the Commissioner shall be authorized to obtain conviction data with respect to an applicant as authorized in this Code section. The Commissioner shall submit to the Georgia Crime Information Center two complete sets of fingerprints of the applicant for appointment or employment, the required records search fees, and such other information as may be required. Upon receipt of such material, the Georgia Crime Information Center shall promptly forward one set of fingerprints to the Federal Bureau of Investigation for a search of bureau records and the preparation of an appropriate report concerning such records search and shall retain the other set and promptly conduct a search of its own records and all records to which the center has access. The Georgia Crime Information Center shall notify the Commissioner in writing of any derogatory finding, including, but not limited to, any conviction data regarding the fingerprint records check or if there is no such finding. All conviction data received by the Commissioner shall not be a public record, shall be privileged, and shall not be disclosed to any other person or

agency except as provided in this Code section and except to any person or agency that otherwise has a legal right to inspect the employment file. All such records shall be maintained by the Commissioner pursuant to the laws regarding such records and the rules and regulations of the Federal Bureau of Investigation and the Georgia Crime Information Center, as applicable.

Amended by 2009 Ga. Laws 107,§ 2, eff. 7/1/2009.

Added by 2008 Ga. Laws 767,§ 4, eff. 7/1/2008.

Section 33-23-6 - Bond requirements for applicants for adjuster's license

In addition to other applicable provisions of this chapter, an applicant for a public adjuster's license must have previously filed a bond as required by rule or regulation of the Commissioner.

Amended by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-7 - Bond requirement for applicants for counselor's license

In addition to other applicable provisions of this chapter, an applicant for a counselor's license must have previously filed a bond as required by rule or regulation by the Commissioner.

Amended without change by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-8 - Form and contents of license application; fees

(a) An individual applicant for any license required by this chapter shall file with the Commissioner an application upon forms prescribed by the Commissioner.

(b) If the application is for an agent's or limited subagent's license, the application shall state the kinds of insurance proposed to be transacted. If applying as a limited subagent, the applicant shall be appointed as a limited subagent by a sponsoring agent prior to the issuance of such license.

(c) As to any application for a limited subagent's license or certificate of authority, the Commissioner shall require as part of the application a certificate of the sponsoring agent proposed to be represented. The certificate shall state, relative to the applicant's character, including criminal background, identity, residence, experience, and instruction as to the kinds of insurance to be transacted, that the sponsoring agent is satisfied that the applicant is trustworthy and qualified to act as its limited subagent and to hold himself or herself out in good faith to the general public as a limited subagent and the fact that the sponsoring agent desires that the applicant be licensed as a limited subagent to represent it in this state.

(d) Each applicant for an agency license shall file with the Commissioner the information required under Code Section 33-23-3.

(e) All such applications shall be accompanied by the appropriate fees in the respective amounts as provided by law.

Amended by 2008 Ga. Laws 767,§ 5, eff. 7/1/2008.

Amended by 2005 Ga. Laws 19,§ 33, eff. 4/7/2005.

Amended by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-9 - Study materials for applicants

The rules and regulations of the Commissioner shall designate textbooks, manuals, and other materials to be studied by the applicant in preparation for examinations in each classification designated by the Commissioner. The textbooks, manuals, or other materials may consist of matter available to applicants by purchase from the publisher or may consist of matter prepared at the direction of the Commissioner and distributed to applicants upon request therefor and payment of reasonable costs. When textbooks, manuals, or other materials shall have been designated by or prepared at the direction of the Commissioner, all examination questions shall be prepared from the contents of those textbooks, manuals, or other materials.

Amended without change by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-10 - Examination of applicants

(a) Each individual applicant for a license as agent, limited subagent, counselor, adjuster, or surplus line broker shall submit to a personal examination in writing as to his or her competence to act in such capacity. The examination shall be prepared and given by the Commissioner or a designee of the Commissioner and shall be given and graded in a fair and impartial manner and without unfair discrimination as between individuals examined. Any required examination may be supplemented by an oral examination at the discretion of the Commissioner. The Commissioner shall provide by rule or regulation for a reasonable waiting period before giving a reexamination to an applicant who failed to pass a previous similar examination.

(b) The Commissioner shall by rule or regulation establish criteria and procedures for:

(1) The scope of any examination; and

(2) Exemptions, if any, to examinations, provided that the Commissioner shall not, under any circumstances, exempt himself or herself from any written examination requirements set forth in this Code section.

(c) An applicant for a license to act as an agent, limited subagent, surplus line broker, counselor, or adjuster who held a valid license to act as such which lapsed while the applicant was a member of any branch of the armed forces of the United States shall be granted a new license if application is made within a period of five years from the date of the expiration of the old license and proof satisfactory to the Commissioner is furnished that:

(1) The individual was a member of the armed forces of the United States at the time the previous license lapsed; and

(2) The individual's service in the armed forces of the United States was not terminated more than one year prior to the date of application for a new license.

Amended by 2011 Ga. Laws 112,§ 9, eff. 7/1/2011.

Amended by 2008 Ga. Laws 767,§ 6, eff. 7/1/2008.

Amended by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-11 - Issuance and contents of license; display certificate of licensure

(a) The Commissioner shall issue licenses applied for to persons qualified for the licenses in accordance with this article.

(b) The license shall state the name and address of the licensee, the date of issue, the general conditions relative to expiration or termination, the kind or kinds of insurance covered if not an insurance agency license, and the other conditions of licensing.

(c) Upon the request of a licensee under this chapter, the Commissioner shall provide a certificate of licensure which shall be suitable for display at the business premises of the licensee. The Commissioner shall provide by rule or regulation the application procedures for the certificate and the form and content of the certificate.

(d) The Commissioner shall have the authority to enter into agreements with persons for the purposes of providing licensing testing, administrative, record keeping, printing, mounting, and other services related to the administration of the Commissioner's duties under this article and to set appropriate charges by rule or regulation to cover the costs of such services which shall be in addition to the fees otherwise provided for in this title and may be paid directly to the providers of such services. The Commissioner may require applicants for licenses to pay such charges for licensing testing and for the cost of the printing and mounting of a certificate of licensure which is suitable for display directly to the provider of such services. The

Commissioner may require insurers to pay such charges for licensing testing, administrative, record keeping, and other services provided for in this subsection directly to the provider of such services in an amount corresponding to the number of their authorized agents.

Amended by 2020 Ga. Laws 406,§ 3, eff. 6/30/2020.

Amended by 2019 Ga. Laws 140,§ 6, eff. 7/1/2019.

Amended without change by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-12 - Limited licenses

(a) Except as provided in subsection (b) of this Code section for credit insurance licenses, subsection (b.1) of this Code section, subsection (c) of this Code section for rental companies, subsection (d) of this Code section for portable electronics, and subsection (f) of this Code section for travel insurance, the Commissioner may provide by rule or regulation for licenses which are limited in scope to specific lines or sublines of insurance.

(b)

(1) Licenses shall be issued to individuals for the purpose of writing credit insurance as provided in this subsection.

(2) Resident applicants must be sponsored by an insurer authorized to write credit insurance in this state, and the applicant must certify that he or she has read and understands the provisions of this title and regulations promulgated pursuant to this title which are pertinent to credit insurance in this state.

(3) Nonresident applicants must follow the appointment process set forth in subsection (g) of Code Section 33-23-16.

(4) No prelicensing education or prelicensing examination shall be required for issuance of such license, and the insurer shall certify that the licensee has completed a minimum of five hours of self-study in credit insurance subjects.

(5) The lines or sublines of insurance included in the scope of authority of credit insurance licenses issued under this Code section shall include, but not be limited to, the following:

(A) Credit life and credit accident and sickness insurance;

(B) Credit casualty insurance;

(C) Credit property insurance;

(D) Credit unemployment insurance;

(E) Accidental death and dismemberment insurance;

(F) Nonfiling or nonrecording insurance;

(G) Vendors' single interest insurance; and

(H) Any other lines or sublines of insurance which may become accepted as credit insurance by the insurance and lending industries unless otherwise disapproved by the Commissioner.

(b.1)

(1) In lieu of requiring individual employees to obtain a limited credit insurance license pursuant to the provisions of subsection (b) of this Code section, any business entity that sells, solicits, or negotiates the lines or sublines of credit insurance pursuant to paragraph (5) of subsection (b) of this Code section may make application to the Commissioner for a limited credit insurance agency license so long as:

(A) The entity examines the character and fitness of each of its employees that sell, solicit, or negotiate credit insurance on its behalf to the satisfaction of the Commissioner, including but not limited to performing criminal background checks;

(B) The entity provides at least five hours of training in minimum basic insurance concepts and credit insurance subjects to its employees who sell, solicit, or negotiate credit insurance on its behalf prior to allowing these employees to sell, solicit, or negotiate such insurance. The Commissioner shall approve materials for this training course in a manner provided for by rules and regulations. The entity shall maintain records of compliance with this subparagraph and shall submit such records upon the Commissioner's request;

(C) The entity provides at least two hours of annual continuing education courses taught by such entity or an insurer to its employees who sell, solicit, or negotiate credit insurance on its behalf. The Commissioner shall approve materials for this training course by rules and regulations. Such entity shall maintain records of compliance with this subparagraph and shall submit such records upon the request of the Commissioner;

(D) The entity submits to the Commissioner along with its application for licensure a list of employees who sell, solicit, or negotiate credit insurance on behalf of the entity in a manner prescribed by the Commissioner. Such entity shall update such employee list in a manner prescribed by the Commissioner; and

(E) The entity submits to the Commissioner with its application for licensure a list of all physical locations where its employees sell, solicit, or negotiate credit insurance on its behalf. The entity shall update such list in a manner prescribed by the Commissioner.

(2) The entity shall make application to the Commissioner for a limited credit insurance agency license in such form or forms and providing such information as the Commissioner may prescribe and shall pay an initial license fee pursuant to Code Section 33-8-1 or as provided for by rules and regulations.

(3) The lines or sublines of insurance included in the scope of authority of limited credit insurance agency licenses issued under this subsection shall include such licenses as provided for in paragraph (5) of subsection (b) of this Code section.

(4) Any limited credit insurance agency license issued under this subsection shall also authorize any employee of such limited licensee to act individually on behalf and under the supervision of such limited licensee with respect to selling, soliciting, and negotiating the kinds of coverage specified in this subsection only and any such employee shall be authorized to receive related compensation, notwithstanding any other provision of law.

(5) In the event that any provision of this title is violated by a limited licensee or any employee selling, soliciting, or negotiating credit insurance on behalf of such limited licensee, the Commissioner may:

(A) Revoke, suspend, or place on probation the entity's limited credit insurance agency license issued under this subsection in accordance with the provisions of Code Sections 33-23-21 and 33-23-22, and the procedures for notice and the conduct of hearings pursuant to Chapter 2 of this title; or

(B) Impose such other penalties, including but not limited to suspending the transaction of insurance at specific locations where violations of this subsection have occurred as the Commissioner determines to be necessary or convenient to carry out the purposes of this subsection in accordance with the procedures for notice and the conduct of hearings set forth in Chapter 2 of this title.

(6) An appeal from any order or decision of the Commissioner made pursuant to this subsection shall be conducted pursuant to Chapter 2 of this title.

(7) Limited credit insurance agency licenses issued pursuant to this Code section shall renew biennially on December 31 of the applicable renewal year. The entity shall make application for renewal to the Commissioner for such licenses in such form or forms and containing such information required by the Commissioner and

shall pay a renewal license fee pursuant to Code Section 33-8-1 and rules and regulations.

(c)

(1) As used in this subsection, the term:

(A) "Limited licensee" means a person or entity authorized to sell certain coverages relating to the rental of vehicles pursuant to the provisions of this subsection.

(B) "Rental agreement" means any written agreement setting forth the terms and conditions governing the use of a vehicle provided by the rental company for rental or lease.

(C) "Rental company" means any person or entity in the business of providing primarily private passenger vehicles to the public under a rental agreement for a period not to exceed 90 days.

(D) "Rental period" means the term of the rental agreement.

(E) "Renter" means any person obtaining the use of a vehicle from a rental company under the terms of a rental agreement for a period not to exceed 90 days.

(F) "Vehicle" or "rental vehicle" means a motor vehicle of the private passenger type, including passenger vans, minivans, and sport utility vehicles, and of the cargo type, including cargo vans, pick-up trucks, and trucks with a gross vehicle weight of less than 26,000 pounds and which do not require the operator to possess a commercial driver's license.

(2) The Commissioner may issue to a rental company that has complied with the requirements of this subsection a limited license authorizing the limited licensee to offer or sell insurance through a licensed insurer in connection with the rental of vehicles.

(3) As a prerequisite for issuance of a limited license under this subsection, there shall be filed with the Commissioner an application for a limited license in such form or forms, and supplements thereto, and containing such information as the Commissioner may prescribe.

(4) In the event that any provision of this subsection is violated by a limited licensee, the Commissioner may:

(A) After notice and a hearing, revoke or suspend a limited license issued under this subsection in accordance with the provisions of Code Sections 33-23-21 and 33-23-22; or

(B) After notice and a hearing, impose such other penalties, including suspending the transaction of insurance at specific rental locations where violations of this subsection have occurred, as the Commissioner deems to be necessary or convenient to carry out the purposes of this subsection.

(5) The rental company licensed pursuant to paragraph (2) of this subsection may only offer or sell insurance through licensed insurers in connection with and incidental to the rental of vehicles, whether at the rental office or by preselection of coverage in an individual, master, corporate, or group rental agreement, in any of the following general categories:

(A) Personal accident insurance covering the risks of travel, including, but not limited to, accident and health insurance that provides coverage, as applicable, to renters and other rental vehicle occupants for accidental death or dismemberment and reimbursement for medical expenses resulting from an accident that occurs during the rental period;

(B) Liability insurance, which, at the exclusive option of the rental company, may include uninsured and underinsured motorist coverage, whether offered separately or in combination with other liability 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;

(C) Personal effects insurance that provides coverage, as applicable, to renters and other rental vehicle occupants for the loss of, or damage to, personal effects that occurs during the rental period;

(D) Roadside assistance and emergency sickness protection programs; and

(E) Any other travel or vehicle related coverage that a rental company offers in connection with and incidental to the rental of vehicles.

(6) No insurance shall be offered by a limited licensee pursuant to this subsection unless:

(A) The rental period of the rental agreement does not exceed 90 consecutive days;

(B) At every rental location where rental agreements are executed, brochures or other written materials are readily available to the prospective renter that:

(i) Summarize clearly and correctly the material terms of coverage offered to renters, including the identity of the insurer;

(ii) Disclose that such policies offered by the rental company may provide a duplication of coverage already provided by a renter's personal automobile

insurance policy, homeowner's insurance policy, personal liability insurance policy, or other source of coverage;

(iii) State that the purchase by the renter of the kinds of coverage specified in this subsection is not required in order to rent a vehicle; and

(iv) Describe the process for filing a claim in the event the renter elects to purchase coverage and in the event of a claim; and

(C) Evidence of coverage on the face of the rental agreement is disclosed to every renter who elects to purchase such coverage.

(7) Any limited license issued under this subsection shall also authorize any employee of the limited licensee to act individually on behalf and under the supervision of the limited licensee with respect to the kinds of coverage specified in this subsection.

(8) Each rental company licensed pursuant to this subsection shall provide a training program in which employees being trained by an instructor licensed under this article receive basic insurance instruction about the kinds of coverage specified in this subsection and offered for purchase by prospective renters of rental vehicles. Additionally, each rental company shall provide for such employees two hours of continuing education courses annually to be taught by an instructor licensed under this article. A rental company shall certify that, prior to offering such coverages, each employee has received such instruction.

(9) Notwithstanding any other provision of this subsection or any rule adopted by the Commissioner, a limited licensee pursuant to this subsection shall not be required to treat moneys collected from renters purchasing such insurance when renting vehicles as funds received in a fiduciary capacity, provided that the charges for coverage shall be itemized and be ancillary to a rental transaction. The sale of insurance not in conjunction with a rental transaction shall not be permitted.

(10) No limited licensee under this subsection shall advertise, represent, or otherwise hold itself or any of its employees out as licensed insurers, insurance agents, or insurance brokers.

(d)

(1) As used in this subsection, the term:

(A) "Customer" means a person who purchases portable electronics or services.

(B) "Enrolled customer" means a customer who elects coverage under a portable electronics insurance policy issued to a vendor of portable electronics.

(C) "Location" means any physical location in this state or any website, call center site, or similar location directed to residents of this state.

(D) "Portable electronics" means handsets, pagers, personal digital assistants, portable computers, automatic answering devices, cellular telephones, batteries, and other similar devices and their accessories and includes services related to the use of such devices, including, but not limited to, individual customer access to a wireless network.

(E) "Portable electronics insurance" means insurance providing coverage for the repair or replacement of portable electronics which may provide coverage for portable electronics against any one or more of the following: loss, theft, inoperability due to mechanical failure, malfunction, damage, or other similar causes of loss. Such term shall not include a service contract or extended warranty providing coverage limited to the repair, replacement, or maintenance of property in cases of operational or structural failure due to a defect in materials, workmanship, accidental damage from handling power surges, or normal wear and tear.

(F) "Portable electronics transaction" means the sale or lease of portable electronics by a vendor to a customer or the sale of a service related to the use of portable electronics by a vendor to a customer.

(G) "Supervising entity" means a business entity that is a licensed insurer, or insurance producer that is authorized by a licensed insurer, to supervise the administration of a portable electronics insurance program.

(H) "Vendor" means a person in the business of engaging in portable electronics transactions directly or indirectly.

(2) The Commissioner may issue to a retail vendor of portable electronics that has complied with the requirements of this subsection a limited license authorizing the limited licensee to offer or sell portable electronics insurance policies.

(3) A limited license issued under this subsection shall authorize any employee or authorized representative of the vendor to sell or offer coverage under a policy of portable electronics insurance to customers at each location where the vendor engages in portable electronics transactions.

(4) The supervising entity shall maintain a registry of vendor locations that are authorized to sell or solicit portable electronics insurance coverage in this state. Upon request by the Commissioner and with ten days' notice to the supervising entity, the registry shall be open to inspection and examination by the Commissioner during regular business hours of the supervising entity.

(5) The sale of such insurance policies shall be limited to sales in connection with the sale of or provision of service for portable electronics by the retail vendor.

(6) At every location where portable electronics insurance is offered to customers, brochures or other written materials shall be made available to a prospective customer which:

(A) State that the enrollment by the customer in a portable electronics insurance program is not required in order to purchase or lease portable electronics or services;

(B) Summarize the material terms of the insurance coverage, including:

(i) The identity of the insurer;

(ii) The identity of the supervising entity;

(iii) The amount of any applicable deductible and how it is to be paid;

(iv) Benefits of the coverage; and

(v) Key terms and conditions of coverage such as whether portable electronics may be repaired or replaced with a similar make and model or with reconditioned or nonoriginal manufacturer parts or equipment;

(C) Summarize the process for filing a claim, including a description of how to return portable electronics and the maximum fee applicable in the event the customer fails to comply with any equipment return requirements; and

(D) State that an enrolled customer may cancel enrollment for coverage under a portable electronics insurance policy at any time and the person paying the premium shall receive a refund of any applicable unearned premium.

(7) Portable electronics insurance may be offered on a month-to-month or other periodic basis as a group or master commercial inland marine policy issued to a vendor of portable electronics for its enrolled customers. Coverage under portable electronics insurance shall be primary to any other insurance.

(8) Eligibility and underwriting standards for customers electing to enroll in coverage shall be established for each portable electronics insurance program.

(9) Notwithstanding any other provision of law, employees or authorized representatives of a vendor of portable electronics shall not be compensated based primarily on the number of customers enrolled for portable electronics insurance coverage but may receive compensation for activities under the limited license which are incidental to their overall compensation.

(10) The charges for portable electronics insurance coverage may be billed and collected by the vendor of portable electronics. Any charge to the enrolled customer for coverage that is not included in the cost associated with the purchase or lease of portable electronics or related services, shall be separately itemized on the enrolled customer's bill. If the portable electronics insurance coverage is included with the purchase or lease of portable electronics or related services, the vendor shall clearly and conspicuously disclose to the enrolled customer that the portable electronics insurance coverage is included with the portable electronics or related services. Vendors billing and collecting such charges shall not be required to maintain such funds in a segregated account, provided that the vendor is authorized by the insurer to hold such funds in an alternative manner and remits such amounts to the supervising entity within 60 days of receipt. All funds received by a vendor from an enrolled customer for the sale of portable electronics insurance shall be considered funds held in trust by the vendor in a fiduciary capacity for the benefit of the insurer. Vendors may receive compensation for billing and collection services.

(11) As a prerequisite for issuance of a limited license under this subsection, there shall be filed with the Commissioner an application for such limited license or licenses in a form and manner prescribed by the Commissioner. The application shall provide:

(A) The name, residence address, and other information required by the Commissioner of an employee or officer of the vendor that is designated by the applicant as the person responsible for the vendor's compliance with the requirements of this subsection;

(B) If the vendor derives more than 50 percent of its revenue from the sale of portable electronics insurance, the information required by subparagraph (A) of this paragraph for all officers, directors, and shareholders of record having beneficial ownership of 10 percent or more of any class of securities registered under the federal securities law; and

(C) The location of the applicant's home office.

(12) The employees and authorized representatives of vendors may sell or offer portable electronics insurance to customers and shall not be subject to licensure as an insurance producer under this Code section, provided that the supervising entity supervises the administration of a training program in which employees and authorized representatives of a vendor shall be trained and receive basic insurance instruction about the kind of coverage authorized in this subsection and offered for purchase by prospective purchasers. The training required by this subsection may

be provided in electronic form. However, if provided in electronic form, the supervising entity shall implement a supplemental education program regarding the portable electronics insurance that is conducted and overseen by an instructor licensed under this article.

(13) No prelicensing examination shall be required for issuance of such license.

(14) If a vendor or its employee or authorized representative violates any provision of this subsection, the Commissioner may impose any of the following penalties:

(A) After notice and hearing, fines not to exceed $500.00 per violation or $5,000.00 in the aggregate for such conduct;

(B) After notice and hearing, other penalties that the Commissioner deems necessary and reasonable to carry out the purpose of this article, including:

(i) Suspending the privilege of transacting portable electronics insurance pursuant to this subsection at specific business locations where violations have occurred; and

(ii) Suspending or revoking the ability of individual employees or authorized representatives to act under the license;

(15) Notwithstanding any other provision of law:

(A) An insurer may terminate or otherwise change the terms and conditions of a policy of portable electronics insurance only upon providing the policyholder and enrolled customers with at least 60 days' notice;

(B) If the insurer changes the terms and conditions, then such insurer shall provide the vendor with a revised policy or endorsement and each enrolled customer with a revised certificate, endorsement, updated brochure, or other evidence indicating a change in the terms and conditions has occurred and a summary of such changes;

(C) Notwithstanding subparagraph (A) of this paragraph, an insurer may terminate an enrolled customer's enrollment under a portable electronics insurance policy upon 15 days' notice for discovery of fraud or material misrepresentation in obtaining coverage or in the presentation of a claim;

(D) Notwithstanding subparagraph (A) of this paragraph, an insurer may immediately terminate an enrolled customer's enrollment under a portable electronics insurance policy:

(i) For nonpayment of premium;

(ii) If the enrolled customer ceases to have an active service with the vendor of portable electronics; or

(iii) If the enrolled customer exhausts the aggregate limit of liability, if any, under the terms of the portable electronics insurance policy and the insurer sends notice of termination to the enrolled customer within 30 calendar days after exhaustion of the limit. However, if notice is not timely sent, enrollment shall continue notwithstanding the aggregate limit of liability until the insurer sends notice of termination to the enrolled customer; and

(E) When a portable electronics insurance policy is terminated by a policyholder, the vendor shall mail or deliver written notice to each enrolled customer advising the enrolled customer of the termination of the policy and the effective date of termination. The written notice shall be mailed or delivered to the enrolled customer at least 30 days prior to the termination.

(16) Whenever notice or correspondence with respect to a policy of portable electronics insurance is required pursuant to this subsection or is otherwise required by law, it shall be in writing and sent within the notice period, if any, specified within the statute or regulation requiring the notice or correspondence. Notwithstanding any other provision of law, notices and correspondence may be sent either by mail or by electronic means as set forth in this paragraph. If the notice or correspondence is mailed, it shall be sent to the vendor of portable electronics at the vendor's mailing address specified for such purpose and to its affected enrolled customers' last known mailing addresses on file with the insurer. The insurer or vendor of portable electronics, as the case may be, shall maintain proof of mailing in a form authorized or accepted by the United States Postal Service or other commercial mail delivery service. If the notice or correspondence is sent by electronic means, it shall be sent to the vendor of portable electronics at the vendor's email address specified for such purpose and to its affected enrolled customers' last known email address as provided by each enrolled customer to the insurer or vendor of portable electronics, as the case may be. For purposes of this paragraph, an enrolled customer's provision of an email address to the insurer or vendor of portable electronics, as the case may be, shall be deemed as consent to receive notices and correspondence by electronic means. The insurer or vendor of portable electronics, as the case may be, shall maintain proof that the notice or correspondence was sent.

(17) Notice or correspondence required by this subsection or otherwise required by law may be sent on behalf of an insurer or vendor, as the case may be, by the supervising entity appointed by the insurer.

(e)

(1) As used in this subsection, the term:

(A) "Limited licensee" means an owner authorized to act as an agent of an insurance provider for purposes of selling certain insurance coverages for personal property maintained in self-service storage facilities pursuant to this subsection.

(B) "Occupant" means a person, his or her sublessee, successor, or assign entitled to the use of the storage space at a self-service storage facility under a rental agreement, to the exclusion of others.

(C) "Owner" means the owner, operator, lessor, or sublessor of a self-service storage facility, his or her agent, or any other person authorized by him or her to manage the self-service storage facility or to receive rent from an occupant under a rental agreement.

(D) "Personal property" means movable property not affixed to land and includes, but is not limited to, goods, wares, merchandise, motor vehicles, watercraft, and household items and furnishings.

(E) "Rental agreement" means any agreement or lease, written or oral, that establishes or modifies the terms, conditions, rules, or any other provisions concerning the use and occupancy of a self-service storage facility.

(F) "Self-service storage facility" means any real property designed and used for the purpose of renting or leasing individual storage space to occupants who are to have access to such for the purpose of storing and removing personal property. No occupant shall use a self-service storage facility for residential purposes. A self-service storage facility is not a warehouse within the meaning of Article 1 of Chapter 4 of Title 10, the "Georgia State Warehouse Act." A self-service storage facility is not a safe-deposit box or vault maintained by banks, trust companies, or other financial entities.

(2) The Commissioner may issue to an owner that is in compliance with the requirements of this subsection a limited license authorizing the limited licensee to offer or sell insurance through a licensed insurer in connection with a self-service storage facility.

(3) A limited licensee shall be authorized to offer or sell insurance on behalf of a licensed insurer only in connection with a rental agreement and only for either an individual policy issued to an individual occupant or as a group policy for occupants for personal property insurance. A limited licensee shall only be authorized to provide to occupants insurance coverage for:

(A) The loss of or damage to personal property stored at a self-service storage facility where the loss or damage occurs at such self-service storage facility during the occupant's rental agreement; or

(B) Such other loss directly related to an occupant's rental agreement.

(4) No insurance shall be issued pursuant to this subsection unless the limited licensee provides to a prospective occupant written material that:

(A) Provides a summary of the terms of insurance coverage, including the identity of the insurer;

(B) Conspicuously discloses that the policy of insurance may provide a duplication of coverage already provided by an existing policy of insurance;

(C) Describes the process for filing a claim in the event the occupant elects to purchase coverage and experiences a covered loss;

(D) Provides information regarding the price, deductible, benefits, exclusions, conditions, and any other limitations of such policy;

(E) States that the limited licensee is not authorized to evaluate the adequacy of the occupant's existing insurance coverages, unless such limited licensee is otherwise licensed; and

(F) States that the occupant may cancel the insurance at any time, and any unearned premium will be refunded in accordance with applicable law.

(5) Notwithstanding any other provision of this subsection or any rule adopted by the Commissioner, a limited licensee licensed pursuant to this subsection shall not be required to treat moneys collected from occupants under rental agreements as funds received in a fiduciary capacity, provided that the charges for coverage shall be itemized and be ancillary to a rental agreement. The sale of insurance not in conjunction with a rental agreement shall not be permitted.

(6) Any limited license issued under this subsection shall also authorize any employee of the limited licensee to act individually on behalf and under the supervision of the limited licensee with respect to the kinds of coverage specified in this subsection.

(7) Each owner licensed pursuant to this subsection shall provide a training program in which employees and authorized representatives of such owner shall be trained by an instructor licensed pursuant to this article and receive basic insurance instruction about the kind of coverage authorized in this subsection and offered for purchase by prospective occupants.

(8) As a prerequisite for issuance of a limited license under this subsection, there shall be filed with the Commissioner an application for a limited license in such form or forms, and supplements thereto, and containing such information as the Commissioner may prescribe.

(9) In the event that any provision of this title is violated by a limited licensee, or an employee of a limited licensee, the limited licensee shall be subject to all penalties, fines, criminal sanctions, and other actions authorized by this title.

(10) No prelicensing examination shall be required for issuance of a limited license pursuant to this subsection.

(f)

(1) As used in this subsection, the term:

(A) "Aggregator site" means a website that provides access to information regarding insurance products from more than one insurer, including product and insurer information, for use in comparison shopping.

(B) "Blanket travel insurance" means a policy of travel insurance issued to any eligible group providing coverage for specific classes of persons defined in the policy with coverage provided to all members of the eligible group without a separate charge to individual members of the eligible group.

(C) "Cancellation fee waiver" means a contractual agreement between a supplier of travel services and its customer to waive some or all of the nonrefundable cancellation fee provisions of the supplier's underlying travel contract with or without regard to the reason for the cancellation or form of reimbursement. Such term shall not be considered insurance.

(D) "Eligible group" means two or more persons that are engaged in a common enterprise or have an economic, educational, or social affinity or relationship, including but not limited to any of the following:

(i) Any entity engaged in the business of providing travel or travel services, including but not limited to:

(I) Tour operators, lodging providers, vacation property owners, hotels and resorts, travel clubs, travel agencies, property managers, or cultural exchange programs; or

(II) Common carriers or the operator, owner, or lessor of a means of transportation of passengers, including but not limited to airlines, cruise lines, railroads, steamship companies, and public bus carriers,

wherein, with regard to any particular travel or type of travel or travelers, all members or customers of the group share a common exposure to risk attendant to such travel;

(ii) Any college, school, or other institution of learning covering students, teachers, employees, or volunteers;

(iii) Any employer covering any group of employees, volunteers, contractors, board of directors, dependents, or guests;

(iv) Any sports team, camp, or sponsor thereof covering participants, members, campers, employees, officials, supervisors, or volunteers;

(v) Any religious, charitable, recreational, educational, or civic organization or branch thereof covering any group of members, participants, or volunteers;

(vi) Any financial institution or financial institution vendor, or any parent holding company, trustee, or agent of or designated by one or more financial institutions or financial institution vendors, including account holders, credit card holders, debtors, guarantors, or purchasers;

(vii) Any incorporated or unincorporated association, including labor unions, that has a common interest, a constitution, and bylaws and that is organized and maintained in good faith for purposes other than obtaining insurance for members or participants of such association in covering its members;

(viii) Any trust or the trustees of a fund established, created, or maintained for the benefit of and for covering members, employees, or customers, subject to the Commissioner permitting the use of a trust and the state's premium tax provisions provided in Code Section 33-8-4 for one or more associations meeting the requirements of division (vii) of this subparagraph;

(ix) Any entertainment production company covering any group of participants, volunteers, audience members, contestants, or workers;

(x) Any volunteer fire department, ambulance, rescue, police, court, first aid, civil defense, or other such volunteer group;

(xi) Any preschool, day-care institution for children or adults, or senior citizen club;

(xii) Any automobile or truck rental or leasing company covering a group of individuals who may become renters, lessees, or passengers as defined by their travel status on the rented or leased vehicles;

(xiii) The common carrier; the operator, owner, or lessor of a means of transportation; or the automobile or truck rental or leasing company that is the policyholder under a policy to which this subsection applies; and

(xiv) Any other group to which the Commissioner has determined that issuance of the policy would not be contrary to the public interest and in which the members are engaged in a common enterprise or have an economic, educational, or social affinity or relationship.

(E) "Fulfillment materials" means documentation sent to the purchaser of a travel protection plan confirming the purchase and providing the travel protection plan's coverage and assistance details.

(F) "Group travel insurance" means travel insurance issued to any eligible group.

(G) "Limited licensee" means a person or entity authorized to sell certain coverages related to travel pursuant to the provisions of this subsection.

(H) "Limited lines travel insurance producer" means a:

(i) Licensed managing general underwriter;

(ii) Licensed managing general agent or third-party administrator;

(iii) Licensed insurance producer, including a limited licensee; or

(iv) Travel administrator.

(I) "Offer and disseminate" means providing general information, including a description of the coverage and price, as well as processing the application and collecting premiums.

(J) "Primary certificate holder" means an individual or person that elects and purchases travel insurance under a group policy.

(K) "Travel administrator" means each person that directly or indirectly underwrites; collects charges, collateral, or premiums from; or adjusts or settles claims for residents of this state in connection with travel insurance; provided, however, that a person shall not be considered a travel administrator if such person's only actions that would otherwise cause it to be considered a travel administrator are among the following:

(i) An insurance producer selling insurance or engaged in administrative and claims related activities within the scope of the producer's license;

(ii) A travel retailer offering and disseminating travel insurance and registered under the license of a limited lines travel insurance producer in accordance with this subsection;

(iii) An individual adjusting or settling claims in the normal course of such individual's practice or employment as an attorney at law and who does not collect charges or premiums in connection with insurance coverage; or

(iv) A business entity that is affiliated with a licensed insurer while acting as a travel administrator for the direct and assumed insurance business of an affiliated insurer.

(L) "Travel assistance services" means:

(i) Noninsurance services for which the consumer is not indemnified based on a fortuitous event and the provision of the service does not result in the transfer or shifting of risk that would constitute the business of insurance;

(ii) Such term shall include, but not be limited to, security advisories; destination information; vaccination and immunization information services; travel reservation services; entertainment; activity and event planning; translation assistance; emergency messaging; international legal and medical referrals; medical case monitoring; coordination of transportation arrangements; emergency cash transfer assistance; medical prescription replacement assistance; passport and travel document replacement assistance; lost luggage assistance; concierge services; and any similar service that is furnished in connection with planned travel; and

(iii) Such term shall not include assistance services that are insurance or related to insurance.

(M) "Travel insurance" means insurance coverage for personal risks incident to planned travel, including:

(i) Interruption or cancellation of trip or event;

(ii) Loss of baggage or personal effects;

(iii) Damages to accommodations or rental vehicles;

(iv) Sickness, accident, disability, or death occurring during travel;

(v) Emergency evacuation;

(vi) Repatriation of remains; or

(vii) Any other contractual obligations to indemnify or pay a specified amount to the traveler upon determinable contingencies related to travel as approved by the Commissioner.

Travel insurance shall not include major medical plans which provide comprehensive medical protection for travelers with trips lasting six months or longer, including, but not limited to, those working or residing overseas as an expatriate, or any other product that requires a specific insurance producer license.

(N) "Travel protection plan" means any plan that provides for travel insurance, travel assistance services, or cancellation fee waivers.

(O) "Travel retailer" means a business entity that makes, arranges, or offers travel services and that may offer and disseminate travel insurance as a service to its customers on behalf of and under the direction of a limited lines travel insurance producer.

(2)

(A) Notwithstanding any other provision of law, the Commissioner may issue to an individual or business entity that has complied with the requirements of this subsection a limited lines travel insurance producer license which authorizes the limited lines travel insurance producer to sell, solicit, or negotiate travel insurance through a licensed insurer.

(B) As a prerequisite for issuance of a limited license under this subsection, there shall be filed with the Commissioner an application for such limited license in a form and manner prescribed by the Commissioner.

(C) Notwithstanding any other provision of law, a travel retailer may offer and disseminate travel insurance under a limited lines travel insurance producer business entity license only if the following conditions are met:

(i) The limited lines travel insurance producer or travel retailer provides to purchasers of travel insurance:

(I) A description of the material terms or the actual material terms of the insurance coverage;

(II) A description of the process for filing a claim;

(III) A description of the review or cancellation process for the travel insurance policy; and

(IV) The identity and contact information of the insurer and limited lines travel insurance producer;

(ii) At the time of licensure, the limited lines travel insurance producer shall establish and maintain a register on a form prescribed by the Commissioner of each travel retailer that offers travel insurance on the limited lines travel insurance producer's behalf. The register shall be maintained and updated by the limited lines travel insurance producer and shall include the name, address, and contact information of the travel retailer and an officer or person who directs or controls the travel retailer's operations and the travel retailer's federal tax identification number. The limited lines travel insurance producer shall submit such register to the Insurance Department upon reasonable request. The limited lines travel insurance producer shall also certify that the travel retailer registered complies with 18 U.S.C. Section 1033. The grounds for the suspension and revocation and the penalties applicable to resident insurance providers shall be applicable to limited lines travel insurance producers and travel retailers;

(iii) The limited lines travel insurance producer shall designate one of its employees who is a licensed individual producer as the person responsible for the limited lines travel insurance producer's compliance with the travel insurance laws and rules and regulations of this state;

(iv) The employee designated as provided in division (iii) of this subparagraph, president, secretary, treasurer, and any other officer or person who directs or controls the limited lines travel insurance producer's insurance operations shall comply with the fingerprinting requirements applicable to insurance producers in the resident state of the limited lines travel insurance producer;

(v) The limited lines travel insurance producer shall pay all applicable insurance producer licensing fees as set forth in applicable state law;

(vi) The limited lines travel insurance producer shall require each employee or authorized representative of the travel retailer whose duties include offering and disseminating travel insurance to receive a program of instruction or training, which may be subject to review by the Commissioner. The training material shall, at a minimum, contain instructions on the types of insurance offered, ethical sales practices, and required disclosures to prospective customers; and

(vii) No prelicensing examination or continuing education shall be required for issuance of a limited license pursuant to this subsection.

(D) Any travel retailer offering or disseminating travel insurance shall make available to prospective purchasers brochures or other written materials that:

(i) Provide the identity and contact information of the insurer and the limited lines travel insurance producer;

(ii) Explain that the purchase of travel insurance is not required in order to purchase any other product or service from the travel retailer; and

(iii) Explain that an unlicensed travel retailer is permitted to provide general information about the insurance offered by the travel retailer, including a description of the coverage and price, but is not qualified or authorized to answer technical questions about the terms and conditions of the insurance offered by the travel retailer or to evaluate the adequacy of the customer's existing insurance coverage.

(E) A travel retailer employee or authorized representative that is not licensed as an insurance producer shall not:

(i) Evaluate or interpret the technical terms, benefits, and conditions of the offered travel insurance coverage;

(ii) Evaluate or provide advice concerning a prospective purchaser's existing insurance coverage; or

(iii) Hold itself out as a licensed insurer, licensed producer, or insurance expert.

(3) Notwithstanding any other provision of law, a travel retailer whose insurance related activities, and those of its employees or authorized representatives, are limited to offering and disseminating travel insurance on behalf of and under the direction of a limited lines travel insurance producer meeting the conditions stated in this subsection shall be authorized to do so and receive related compensation upon registration by the limited lines travel insurance producer as provided in subparagraph (C) of paragraph (2) of this subsection.

(4) As the insurer designee, the limited lines travel insurance producer shall be responsible for the acts of the travel retailer and authorized representative and shall use reasonable means to ensure compliance by the travel retailer with this subsection.

(5) The limited lines travel insurance producer and any travel retailer or authorized representative offering and disseminating travel insurance under the limited lines travel insurance producer's license shall be subject to the unfair trade practices provisions under Article 1 of Chapter 6 of this title and to the other provisions of this article relating to insurance producers.

(6)

(A) The requirements of this subsection shall apply to travel insurance which covers any resident of this state; is sold, solicited, negotiated, or offered in this state; or for which policies and certificates are delivered or issued for delivery in this state; provided, however, that such requirements shall not apply to cancellation fee waivers and travel assistance services, except as expressly provided in this subsection.

(B) All other applicable provisions of the state's insurance laws shall continue to apply to travel insurance except that the specific provisions of this subsection shall supersede any general provisions of law that would otherwise be applicable to travel insurance.

(7) Any person licensed in a major line of authority as an insurance producer shall be authorized to sell, solicit, and negotiate travel insurance. A property and casualty insurance producer shall not be required to become appointed by an insurer in order to sell, solicit, or negotiate travel insurance.

(8)

(A) Each travel insurer shall pay the tax levied by Code Section 33-8-4 with respect to travel insurance premiums paid by any of the following:

(i) An individual primary policyholder who is a resident of this state;

(ii) A primary certificate holder who is a resident of this state who elects coverage under a group travel insurance policy; or

(iii) A blanket travel insurance policyholder that is a resident in or has its principal place of business or the principal place of business of an affiliate or subsidiary that has purchased blanket travel insurance in this state for eligible blanket group members, subject to any apportionment rules which apply to the insurer across multiple taxing jurisdictions or that permits the insurer to allocate premiums on an apportioned basis in a reasonable and equitable manner in such jurisdictions.

(B) Each travel insurer shall:

(i) Document the state of residence or principal place of business of the policyholder or certificate holder, as described in subparagraph (A) of this paragraph; and

(ii) Report as premiums only the amount allocable to travel insurance and shall not report any amounts received for travel assistance services or cancellation fee waivers.

(9) A travel protection plan may be offered for one price for the combined features that the travel protection plan offers in this state if:

(A) The travel protection plan clearly discloses to the consumer at or prior to the time of purchase that it includes travel insurance, travel assistance services, and cancellation fee waivers, as applicable, and provides information and an opportunity at or prior to the time of purchase for the consumer to obtain additional information regarding the features and pricing of each; and

(B) The fulfillment materials:

(i) Describe and delineate the travel insurance, travel assistance services, and cancellation fee waivers in the travel protection plan; and

(ii) Include the travel insurance disclosures and the contact information for persons providing travel assistance services and cancellation fee waivers, as applicable.

(10)

(A) Offering or selling a travel insurance policy that could never result in payment of any claims for any insured under the policy is considered an unfair trade practice under Chapter 6 of this title.

(B)

(i) All documents provided to consumers prior to the purchase of travel insurance, including but not limited to sales materials, advertising materials, and marketing materials, shall be consistent with the travel insurance policy itself, which shall include but not be limited to respective forms, endorsements, policies, rate filings, and certificates of insurance.

(ii) For travel insurance policies or certificates that contain preexisting condition exclusions, information and an opportunity to learn more about the preexisting condition exclusions shall be provided at some point prior to the time of purchase and in the coverage's fulfillment materials.

(iii) The fulfillment materials and the information described in division (f)(2)(c)(i) of this Code section shall be provided to a policyholder or primary certificate holder as soon as practicable following the purchase of a travel protection plan. Unless the insured has either started a covered trip or filed a claim under the travel insurance coverage, a policyholder or primary certificate holder may cancel a policy or certificate for a full refund of the travel protection plan price from the date of purchase of a travel protection plan until at least:

(I) Fifteen days following the date of delivery of the travel protection plan's fulfillment materials by postal mail; or

(II) Ten days following the date of delivery of the travel protection plan's fulfillment materials by means other than postal mail.

For the purposes of this division, the term "delivery" means handing fulfillment materials to the policyholder or primary certificate holder or sending fulfillment materials by postal mail or electronically to the policyholder or primary certificate holder.

(iv) Each company shall disclose in the policy documentation and fulfillment materials whether the travel insurance is primary or secondary to other applicable coverage.

(v) If travel insurance is marketed directly to a consumer through an insurer's website or by others through an aggregator site, it shall not be considered an unfair trade practice or other violation of law if an accurate summary or short description of coverage is provided on the website, so long as the consumer has electronic access to the full provisions of the policy.

(C) A person offering, soliciting, or negotiating travel insurance or travel protection plans on an individual or group basis shall not do so by using negative option or opt out that would require a consumer to take an affirmative action to deselect

coverage such as unchecking a box on an electronic form when the consumer purchases a trip.

(D) It shall be considered an unfair trade practice to market blanket travel insurance coverage as being free.

(E) If a consumer's destination jurisdiction requires insurance coverage, it shall not be considered an unfair trade practice to require such consumer to choose between the following options as a condition of purchasing a trip or travel package:

(i) Purchasing the coverage required by the destination jurisdiction through the travel retailer or limited lines travel insurance producer supplying the trip or travel package; or

(ii) Agreeing to obtain and provide proof of coverage that meets the destination jurisdiction's requirements prior to departure.

(11)

(A) Notwithstanding any provision of this title to the contrary, a person shall not act or represent itself as a travel administrator for travel insurance in this state unless such person:

(i) Is a licensed property and casualty insurance producer in this state for activities permitted under such producer's license;

(ii) Holds a valid managing general agent (M.A.) license in this state; or

(iii) Holds a valid third-party administrator (TA) license in this state.

(B) A travel administrator and its employees shall be exempt from the licensing requirements provided in paragraph (4) of subsection (a) of Code Section 33-23-4, relating to adjuster licensing, for travel insurance that such travel administrator and its employees administer.

(C) An insurer is responsible for the acts of a travel administrator administering travel insurance underwritten by the insurer and ensuring that the travel administrator maintains all books and records relevant to the insurer to be made available by the travel administrator to the Commissioner upon request.

(12)

(A) Notwithstanding any provision of this title to the contrary, travel insurance shall be classified and filed for purposes of rates and forms as marine and transportation insurance; provided, however, that travel insurance that provides coverage for sickness, accident, disability, or death occurring during travel, either exclusively or in conjunction with related coverages of emergency evacuation or

repatriation of remains, or incidental limited property and casualty benefits, such as baggage or trip cancellation, may be filed by an authorized insurer under either an accident and health line of insurance or as marine and transportation insurance.

(B) Travel insurance may be in the form of an individual, group, or blanket policy.

(C) Eligibility and underwriting standards for travel insurance may be developed and provided based on travel protection plans designed for individual or identified marketing or distribution channels, provided that those standards also meet the state's underwriting standards for marine and transportation insurance.

Amended by 2021 Ga. Laws 181,§ 2, eff. 5/4/2021.

Amended by 2020 Ga. Laws 521,§ 33, eff. 7/29/2020.

Amended by 2019 Ga. Laws 321,§ 33, eff. 5/12/2019.

Amended by 2019 Ga. Laws 140,§ 7, eff. 7/1/2019.

Amended by 2019 Ga. Laws 139,§ 1-93, eff. 7/1/2019.

Amended by 2018 Ga. Laws 553,§ 1, eff. 7/1/2018.

Amended by 2017 Ga. Laws 275,§ 33, eff. 5/9/2017.

Amended by 2014 Ga. Laws 669,§ 33, eff. 4/29/2014.

Amended by 2013 Ga. Laws 230,§ 2, eff. 7/1/2013.

Amended by 2013 Ga. Laws 230,§ 1, eff. 7/1/2013.

Amended by 2013 Ga. Laws 33,§ 33, eff. 4/24/2013.

Amended by 2012 Ga. Laws 776,§ 2, eff. 7/1/2012.

Amended by 2012 Ga. Laws 776,§ 1, eff. 7/1/2012.

Amended by 2012 Ga. Laws 727,§ 3, eff. 7/1/2012.

Amended by 2012 Ga. Laws 727,§ 2, eff. 7/1/2012.

Amended by 2012 Ga. Laws 678,§ 1, eff. 7/1/2012.

Amended by 2008 Ga. Laws 767,§ 7, eff. 7/1/2008.

Amended by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Amended by 2001 Ga. Laws 2, § 33, eff. 2/12/2001.

Section 33-23-13 - Temporary licenses

(a) In the event of the death of an agent or limited subagent, including a temporary agent or limited subagent, or the inability to act as an agent or limited subagent by reason of service in the armed services of the United States, illness or other

disability, or termination of appointment by the insurer, if there is no other individual connected with the agency who is licensed as an agent or limited subagent in regard to insurance of the classification transacted by the agent or limited subagent deceased or unable to act, the Commissioner may issue a temporary license as agent or limited subagent in regard to insurance of such classification to an employee of the agency, to a member of the family of said former agent or limited subagent, or to some associate or to a guardian, receiver, executor, or administrator for the purpose of continuing or winding up the business affairs of the agent, limited subagent, or agency. A temporary license shall be issued only to an applicant who has filed a sworn application upon forms prescribed by the Commissioner. The applicant shall not be required to meet the requirements as to examination, residence, and education required for licensing of agents or limited subagents other than temporary agents. If the Commissioner deems the applicant to be qualified for a temporary license, the Commissioner shall issue the license.

(b) A temporary license may be issued to an individual at the request of an insurer for the purposes of training such individual to act as an agent; provided, however, such individual must perform his or her duties under the supervision of an individual licensed under this article. The Commissioner may prescribe by rules or regulations such further restrictions on such temporary licenses as may be necessary for the protection of the public.

(c) A license issued pursuant to this Code section shall be effective for six months, renewable from time to time for renewal periods of three months in the discretion of the Commissioner; but in no event shall such renewal or any other temporary license of renewal with reference to the same matter extend to a time more than 15 months after the date of the first issuance of a temporary license in such matter.

(d) A temporary license issued pursuant to subsection (a) of this Code section shall authorize the negotiation of renewal policies, the receipt and collection of premiums, and such other acts as are necessary to the continuance of the particular insurance business of the agent or limited subagent. The license shall not authorize the holder thereof to sell, solicit, or negotiate new insurance accounts.

(e) As to any application for a temporary agent's license pursuant to subsection (b) of this Code section, the Commissioner shall require as part of the application a certificate of the insurer proposed to be represented. The certificate shall state, relative to the applicant's character, including criminal background, identity, residence, experience, and instruction as to the kinds of insurance to be transacted, that the insurer is satisfied that such applicant is trustworthy and qualified to act as its temporary agent and to hold himself or herself out in good faith to the general

public as a temporary agent and the fact that the insurer desires that the applicant be licensed as a temporary agent to represent it in this state.

Amended by 2008 Ga. Laws 767,§ 8, eff. 7/1/2008.

Amended by 2005 Ga. Laws 19,§ 33, eff. 4/7/2005.

Amended by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-14 - Probationary licenses

(a) The Commissioner shall have the authority to issue a probationary license to any applicant under this chapter.

(b) A probationary license may be issued for a period of not less than three months and not longer than 24 months and shall be subject to immediate revocation for cause at any time without a hearing.

(c) The Commissioner, at his or her discretion, shall prescribe the terms of probation, may extend the probationary period, or refuse to grant a license at the end of any probationary period.

Amended by 2023 Ga. Laws 265,§ 2, eff. 5/3/2023.

Amended without change by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-15 - Additional licenses

The Commissioner may issue two or more licenses to one individual provided the individual meets all qualifications and conditions for each such license.

Amended without change by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-16 - Licensing of nonresidents

(a) Unless denied licensure pursuant to Code Section 33-23-21, a nonresident person shall receive a nonresident agent's license if:

(1) The person is currently licensed as a resident and in good standing in such person's home state;

(2) The person has submitted the proper request for licensure and has paid the fees required by Code Section 33-8-1;

(3) The person has submitted or transmitted to the Commissioner the application for licensure that the person submitted to such person's home state or, in lieu of the same, a completed uniform application or a form prescribed by the Commissioner by rule or regulation for licensure of nonresident agents; and

(4) The person's home state awards nonresident agent licenses to residents of this state on the same basis.

(b) The Commissioner may verify the agent's licensing status through the producer data base maintained by the National Association of Insurance Commissioners, its affiliates, or subsidiaries.

(c) A nonresident agent who moves from one state to another state or a resident agent who moves from this state to another state shall file a change of address and provide certification from the new resident home state within 30 days of the change in legal residence. No fee or application is required.

(d) Notwithstanding any other provision of this title, a person licensed as a surplus lines broker in such person's home state shall receive a nonresident surplus lines broker license pursuant to subsection (a) of this Code section. Except as to subsection (a) of this Code section, nothing in this Code section otherwise amends or supersedes any portion of this title.

(e) Notwithstanding any other provision of this title, a person licensed as a limited lines credit insurance or other type of limited lines agent in such person's home state shall receive a nonresident limited lines agent license pursuant to subsection (a) of this Code section granting the same scope of authority as granted under the license issued by the agent's home state. For the purposes of this subsection, limited lines insurance is any authority granted by the home state which restricts the authority of the license to less than the total authority prescribed in the associated major lines pursuant to applicable Georgia regulations.

(f) The Commissioner may by rule or regulation implement a renewal process and set expiration dates.

(g)

(1) A nonresident individual agent shall not act as an agent of an insurer unless the agent becomes an appointed agent of that insurer as follows:

(A) To appoint an individual as its agent, the appointing insurer shall file, pursuant to Code Section 33-23-26, a notice of appointment within 15 days from the date of licensure or before the first insurance application is submitted. An insurer may also elect to appoint an agent to all or some insurers within the insurer's holding company system or group by the filing of a single appointment request;

(B) Upon receipt of the notice of appointment, the Commissioner shall verify within a reasonable time, not to exceed 30 days, that the insurance agent is eligible for appointment. If the insurance agent is determined to be ineligible for appointment, the Commissioner shall notify the insurer within five days of such determination; and

(C) An insurer shall pay an appointment fee, in the amount and method of payment set forth in Code Section 33-8-1, for each insurance agent appointed by the insurer.

(2) An insurer shall remit, in a manner prescribed by the Commissioner, a renewal appointment fee in the amount as provided for initial appointments set forth in Code Section 33-8-1.

(3) An agent who is not acting as an agent of an insurer is not required to become appointed.

(h) Applicants whose home state does not require a license to transact business may be licensed in this state, provided that the applicant takes the examination issued by the Commissioner where required pursuant to this chapter and the applicant submits written documentation from his or her resident state demonstrating the lack of licensing requirement and the state's reciprocity with residents from this state. If the resident state does not license independent adjusters, the independent adjuster shall designate as his or her home state any state in which the independent adjuster is licensed and in good standing.

Amended by 2012 Ga. Laws 776,§ 7, eff. 7/1/2012.

Amended by 2012 Ga. Laws 727,§ 8, eff. 7/1/2012.

Amended by 2005 Ga. Laws 19,§ 33, eff. 4/7/2005.

Amended by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-17 - Registration of nonresident representatives to represent life insurers in military installations in foreign countries

An individual who is not a resident of this state may be registered to represent an authorized life insurer domiciled in this state, provided such individual only represents the insurer exclusively at a United States military installation located in a foreign country. The Commissioner may, upon request of the insurer on application forms prescribed by the department and upon payment of an annual registration fee of $25.00, issue a certificate of registration to the individual. An official of the insurer shall certify to the Commissioner that the applicant has the necessary training to hold himself or herself out as a foreign life or accident and sickness insurance representative; and the official of the insurer shall further certify on behalf of his or her insurer that it is willing to be bound by the acts of such applicant within the scope of his or her employment and that such applicant has not had his or her privileges to solicit on or enter any United States military installation revoked, suspended, or restricted in any manner. Such certificate shall expire as of December 31 succeeding the date of its issuance unless it is terminated at an earlier time in accordance with this chapter and Chapter 2 of this title.

Added by 2005 Ga. Laws 108,§ 4, eff. 7/1/2005.

Amended by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-18 - Issuance of license on biennial basis; filing for renewal; continuing education requirements

(a) All resident agent, limited subagent, adjuster, and counselor licenses, with the exception of temporary or probationary licenses, shall be issued on a biennial basis and shall expire on the last day of the licensee's birth month.

(b) Resident agent, limited subagent, adjuster, and counselor licenses may be renewed upon receipt by the Commissioner of evidence of such continuing education as the Commissioner may establish by rule or regulation and payment of such fees as are provided by law.

(c) Renewal of the license on forms prescribed by rule or regulation must be made prior to the last day of the licensee's birth month and biennially thereafter.

(d) Continuing education requirements imposed by the Commissioner pursuant to this Code section shall not exceed 15 classroom hours for each licensed individual who has held a license for less than 20 years during the year. For those individuals who have held a license for 20 years or more, the requirement shall be no more than ten classroom hours during the year. However, the Commissioner may provide by rule or regulation for continuing education requirements on a biennial basis.

(e) Any individual who has been licensed as an agent for ten consecutive years or more and who does not perform any of the functions specified in paragraph (3) of subsection (a) of Code Section 33-23-1 other than receipt of renewal or deferred commissions shall be exempt from continuing education requirements; provided, however, that if such individual wishes to again perform any of the other functions specified in said paragraph, such individual must obtain approval from the Commissioner and comply with the requirements of this chapter, including without limitation the requirements for continuing education. The Commissioner may provide, by rule or regulation, for any other exemption to or reduction in continuing education required under this Code section.

(f) Every individual required to participate in a continuing education program pursuant to this Code section, or such individual's insurer, shall furnish the Commissioner such information as the Commissioner deems necessary to verify compliance with the continuing education requirements.

(g) The Commissioner by rule or regulation may establish the following:

(1) Staggered deadlines for the filing of forms for renewal of licenses and the corresponding required fees; and

(2) Penalties and procedures for licensees who fail to comply with subsection (c) of this Code section.

Amended by 2019 Ga. Laws 140,§ 8, eff. 7/1/2019.

Amended by 2012 Ga. Laws 419,§ 2, eff. 3/22/2012.

Amended by 2011 Ga. Laws 220,§ 3, eff. 5/12/2011.

Amended by 2008 Ga. Laws 767,§ 9, eff. 7/1/2008.

Amended by 2005 Ga. Laws 19,§ 33, eff. 4/7/2005.

Amended by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-19 - Placing of license on inactive status; subsequent revocation

(a) An agent's license shall be placed on inactive status when the agent no longer has on file with the Commissioner a certificate of authority to represent at least one insurer licensed to do business in this state.

(b) When a license is placed on inactive status under this Code section, the agent shall be prohibited from selling, soliciting, or negotiating insurance.

(c) During the time a license is in inactive status under the provisions of this Code section, the licensee still shall be required to provide evidence of compliance with the continuing education requirements of Code Section 33-23-18.

Amended by 2008 Ga. Laws 767,§ 10, eff. 7/1/2008.

Amended by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-20 - Effect of license suspension or placement of license on inactive status

(a) The suspension of the license of an agent or limited subagent or the placing of such license on inactive status shall not deprive such individual or the executors or administrators of such individual's estate of any right that may have been acquired by a contract made before such suspension or placement on inactive status to receive all or a portion of commissions upon contracts of insurance written before such suspension or placement on inactive status with reference to the periods of time during which such contracts are in effect, including renewal option periods provided in the contracts.

(b) In case of a sale of an agency upon a work-out basis, the seller without maintaining his or her license or the executors and administrators of the seller's

estate may participate in the proceeds of premiums on insurance written by the purchaser of the agency when and as authorized to do so by the contract of sale of the agency; and this participation may be without limitation of time after the seller ceased to hold a license. An agent whose license has been suspended or placed in inactive status may, when the countersignature of a resident licensed agent is required pursuant to Code Section 33-3-26 and if authorized by the insurer, countersign certificates and endorsements necessary to continue coverage to the expiration date, including renewal option periods.

(c) Nothing in this article shall be construed to permit an agent or limited subagent whose license has been suspended or placed in inactive status to sell, solicit, or negotiate insurance other than as expressly permitted in subsections (a) and (b) of this Code section.

Amended by 2019 Ga. Laws 140,§ 9, eff. 7/1/2019.

Amended by 2008 Ga. Laws 767,§ 11, eff. 7/1/2008.

Amended by 2005 Ga. Laws 19,§ 33, eff. 4/7/2005.

Amended by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-21 - Grounds for refusal, suspension, or revocation of license

A license, other than a probationary license, may be refused or a license duly issued may be suspended or revoked by the Commissioner if the Commissioner finds that the applicant for or holder of the license:

(1) Has violated any provision of this title, of any other law or regulation of this state relating to insurance, or the law or regulation of any jurisdiction, including those of a military installation, relating to the transaction of insurance;

(2) Has misrepresented or concealed any material fact in any application for a license or on any form filed with the Commissioner;

(3) Has obtained or attempted to obtain the license by misrepresentation, concealment, or other fraud;

(4) Has misappropriated, converted to his or her own use, or illegally withheld money belonging to an insurer, insured, agent, agency, applicant, or a beneficiary;

(5) Has committed fraudulent or dishonest practices;

(6) Has materially misrepresented the terms and conditions of an insurance policy or contract;

(7) Has failed to pass an examination pursuant to this article, or cheated on any examination required for a license;

(8) Has failed to comply with or has violated any proper order, rule, or regulation, issued by the Commissioner, including any order issued by the Commissioner or the Commissioner's designated representative during the course of any administrative hearing proceeding;

(9) Is not in good faith carrying on business as an agent or subagent, but, on the contrary, is holding such license for the purpose of securing rebates or commissions or controlled business;

(10) Is not in good faith carrying on business as a licensee under this chapter;

(11) Has shown lack of trustworthiness or lack of competence to act as an licensee under this chapter;

(12) Has knowingly participated in the writing or issuance of substantial overinsurance of any property insurance risk;

(13) Has failed or refused, upon written demand, to pay over to any insurer, agent, agency, applicant, beneficiary, or insured any moneys which belong to such insurer, agent, agency, applicant, beneficiary, or insured;

(14) Has failed to provide documentation or records, or refused to appear:

(A) In compliance with Code Section 33-2-12 or 33-2-13;

(B) In response to a written demand by the Commissioner sent by registered or certified mail or statutory overnight delivery to the last known address of the licensee as shown in the records of the Commissioner; or

(C) In support of an application for license or renewal of license upon request by the department or as otherwise required by the application or renewal;

(15) Has been convicted of any felony or of any crime involving moral turpitude in the courts of this state or any other state, territory, or country or in the courts of the United States; as used in this paragraph and paragraph (16) of this subsection, the term "felony" shall include any offense which, if committed in this state, would be deemed a felony, without regard to its designation elsewhere; and, as used in this paragraph, the term "conviction" shall include a finding or verdict of guilty or a plea of guilty, regardless of whether an appeal of the conviction has been sought;

(16) Has been arrested, charged, and sentenced for the commission of any felony, or any crime involving moral turpitude, where:

(A) First offender treatment without adjudication of guilt pursuant to the charge was granted; or

(B) An adjudication of guilt or sentence was otherwise withheld or not entered on the charge.

The order entered pursuant to the provisions of Article 3 of Chapter 8 of Title 42, relating to probation of first offenders, or other first offender treatment shall be conclusive evidence of arrest and sentencing for such crime;

(17) Has failed to report to the Commissioner any criminal prosecution of the applicant or licensee taken in any jurisdiction. The report shall include a copy of the initial complaint filed, the order resulting from any hearing that has taken place, and any other relevant legal documents. Such report must be filed with the application or within 30 days of the date of arrest;

(18) Has had a license to practice a business or profession licensed under the laws of this state or any other state, territory, country, or the United States revoked, suspended, or annulled by any lawful licensing authority; had other disciplinary action taken against him or her by any such lawful licensing authority; was denied or refused a license by any such lawful licensing authority pursuant to disciplinary proceedings; or was refused the renewal of a license by any such lawful licensing authority pursuant to disciplinary proceedings;

(19) Has failed to notify the Commissioner within 60 days of any event referred to in paragraph (15), (16), or (18) of this Code section;

(20) Is not in compliance with an order for child support as defined by Code Section 19-6-28.1 or 19-11-9.3; for violations of this paragraph only, any hearing and appeal procedures conducted pursuant to such Code sections shall be the only such procedures required to suspend, deny, or revoke any license under this title;

(21) In relation to the licensee's ability to transact the business of insurance, has had a license, permit, authorization, registration, or privilege refused, revoked, suspended, limited, or restricted by any federal, state, county, municipality, territory, military, or other legal authority authorized to issue licenses, permits, authorizations, registrations, or privileges to conduct business within its respective jurisdiction; otherwise has failed to comply with the legal requirements related to the license, permit, authorization, registration, or privilege; or has had other disciplinary action taken against him or her by any such lawful authority; or

(22) Has failed to report to the department within 60 days of the action taken, any refusal, revocation, suspension, limitation, or restriction of any license, permit, authorization, registration, or privilege of any lawful authority referenced in paragraph (18) or (21) of this Code section.

Amended by 2020 Ga. Laws 521,§ 33, eff. 7/29/2020.

Amended by 2019 Ga. Laws 146,§ 1-8, eff. 7/1/2019.

Amended by 2005 Ga. Laws 108,§ 5, eff. 7/1/2005.

Amended by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-21.1 - Licensing for educational borrowers in default

The Commissioner shall not refuse to issue nor suspend or revoke a license of an applicant for or holder of a license because he or she has been certified by any entity of the federal government for nonpayment or default or breach of a repayment or service obligation under any federal educational loan, loan repayment, or service conditional scholarship program.

Amended by 2024 Ga. Laws 399,§ 2-34, eff. 6/30/2024.

Added by 2019 Ga. Laws 146,§ 1-9, eff. 7/1/2019.

Section 33-23-22 - Notice of suspension or revocation of license; hearing; appeals

(a) Any license, other than a probationary license or inactive license as described in subsection (a) of Code Section 33-23-19, may be suspended or revoked as provided by Code Section 33-23-21 and subsection (b) of Code Section 33-23-19, and the Commissioner shall give notice of such action to the applicant for or holder of the license and any insurer or agent whom the applicant or licensee represents or who desires that the applicant or licensee be licensed. The procedure for conduct of hearings set forth in Chapter 2 of this title shall be followed in all cases except those cases pursuant to paragraph (20) of Code Section 33-23-21 which shall only require the hearings provided for in said paragraph.

(b) Appeal from any order or decision of the Commissioner made pursuant to this chapter shall be taken as provided in Chapter 2 of this title.

Amended by 2019 Ga. Laws 146,§ 1-10, eff. 7/1/2019.

Amended by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-23 - Limitation on application after refusal or revocation of license; effect of surrender of license under written consent order

(a) No licensee or applicant whose license or application has been refused or revoked as provided by Code Sections 33-23-21 and 33-23-22 shall be entitled to file another application for a license as an agent, agency, limited subagent, surplus lines broker, counselor, or adjuster within five years from the effective date of the refusal, revocation, or, if judicial review of such refusal or revocation is sought, within five years from the date of the final court order or decree affirming such refusal or revocation.

(b) The application when filed may be refused by the Commissioner unless the applicant shows good cause why the refusal or revocation of the license shall not be deemed a bar to the issuance of a new license.

(c) Any surrender of a license under written consent order shall have the same effect as a revocation under subsections (a) and (b) of this Code section.

(d) At the Commissioner's discretion, an applicant whose application was refused under subsection (a) or (b) of this Code section may be permitted to file an application for a license; provided, however, that such application shall be filed no less than one year from the effective date of the refusal.

Amended by 2023 Ga. Laws 265,§ 3, eff. 5/3/2023.

Amended by 2019 Ga. Laws 140,§ 10, eff. 7/1/2019.

Amended by 2008 Ga. Laws 767,§ 12, eff. 7/1/2008.

Amended by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-24 - Permits and licenses not transferable

The permits of service representatives and licenses of licensees under this article shall not be transferable.

Amended without change by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-25 - Place of business

Every licensed agent, limited subagent, counselor, and adjuster shall have and maintain in this state or, if a nonresident licensee, in the state of domicile, a place of business accessible to the public. The place of business shall be that wherein the licensee principally conducts transactions pursuant to the license. The address of the place of business shall be maintained by the Commissioner. All resident and nonresident licensees shall promptly notify the Commissioner in writing within 30 days of any change in the business address.

Amended by 2008 Ga. Laws 767,§ 13, eff. 7/1/2008.

Amended by 2006 Ga. Laws 667,§ 8, eff. 7/1/2006.

Amended by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-26 - Agent's certificate of authority

(a) Each insurer authorized to transact insurance in this state shall obtain an agent's certificate of authority for each agent representing such insurer in the selling, soliciting, or negotiating of contracts of insurance in this state. For the purposes of this subsection, the insurer will be deemed to have obtained a

certificate of authority for its designated agent immediately upon submission of the appointment request to the Commissioner; provided, however, that the initial certificate of authority for an applicant for licensure shall not become effective until the date such applicant is finally granted a license by the Commissioner.

(b) All agents' certificates of authority shall be renewed by the insurer in such form and manner as the Commissioner may prescribe by rule or regulation.

(c) The fee for each agent's certificate of authority or renewal thereof shall be as provided in Code Section 33-8-1.

(d) An insurer or authorized representative of the insurer that terminates the appointment, employment, contract, or other insurance business relationship with an agent shall notify the Commissioner within 30 days following the effective date of the termination, using a format prescribed by the Commissioner, if the reason for the termination is one of the reasons set forth in Code Section 33-23-21 or the insurer has knowledge that the agent was found to have engaged in any of the activities in Code Section 33-23-21 by a court, governmental body, or self-regulatory organization authorized by law. Upon the written request of the Commissioner, the insurer shall provide additional information, documents, records, or other data pertaining to the termination or activity of the agent.

(e) If an agent's certificate of authority is terminated, the insurer promptly shall give notice of said termination and the effective date of the termination to the Commissioner and to the agent where reasonably possible. The Commissioner may also require the insurer to demonstrate to the satisfaction of the Commissioner that the insurer has made a reasonable effort to give notice to the agent.

(f) An insurer or authorized representative of the insurer that terminates the appointment, employment, or contract with an agent for any reason not set forth in Code Section 33-23-21 shall notify the Commissioner within 30 days following the effective date of the termination, using a format prescribed by the Commissioner. Upon written request of the Commissioner, the insurer shall provide additional information, documents, records, and other data pertaining to such termination.

(g) The insurer or the authorized representative of the insurer shall promptly notify the Commissioner in a format acceptable to the Commissioner if, upon further review or investigation, the insurer discovers additional information that would have been reportable to the Commissioner in accordance with subsection (d) of this Code section had the insurer known of its existence.

(h) No certificate of authority shall be required for an agent who places surplus lines insurance with or through a surplus lines broker only with respect to such surplus lines insurance.

(i) As to any application for an agent's certificate of authority, the Commissioner shall require as part of the application a certificate of the insurer proposed to be represented. The certificate shall state, relative to the applicant's character, including criminal background, identity, residence, experience, and instruction as to the kinds of insurance to be transacted, that the insurer or sponsoring agent is satisfied that such applicant is trustworthy and qualified to act as its agent in this state.

Amended by 2008 Ga. Laws 767,§ 14, eff. 7/1/2008.

Amended by 2005 Ga. Laws 19,§ 33, eff. 4/7/2005.

Amended by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-27 - Subagent's certificate of authority

(a) Each agent licensed in this state shall obtain a certificate of authority for each subagent representing such agent in this state.

(b) Each subagent's certificate of authority shall be renewed by the agent not more than once every three years in such form and manner as specified by the Commissioner by rule or regulation.

(c) Each agent shall also be required to inform the Commissioner of any termination of or change to any certificate of authority for each subagent in such form and manner as may be prescribed by the Commissioner by rule or regulation.

(d) The fee for each subagent's certificate of authority or renewal or duplicate thereof shall be as provided by law.

(e) The subagent's certificate shall be held by the agent and shall be returned to the Commissioner upon termination of the subagent's authority along with an explanation of the reason for such termination in such form and manner as the Commissioner may specify by rule or regulation.

Amended without change by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-28 - Scope of subagent's authority; record of transactions

(a) A subagent's certificate of authority shall not cover any kind of insurance for which the sponsoring agent and subagent are not licensed.

(b) A subagent or limited subagent shall not have power to bind an insurer.

(c) All business transacted by a subagent under such subagent's license or limited subagent shall be in the name of the agent by whom the subagent or limited subagent is employed; and the agent shall be responsible for all the acts or

omissions of the subagent or limited subagent within the scope of his or her employment.

(d) A record of each transaction shall be maintained jointly by the agent and the subagent or limited subagent.

Amended by 2019 Ga. Laws 140,§ 11, eff. 7/1/2019.

Amended by 2008 Ga. Laws 767,§ 15, eff. 7/1/2008.

Amended by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-29 - Authority of agent to act as adjuster; nonresident adjusters; reciprocal agreements

(a) On behalf of and as authorized by an insurer for which he or she is licensed as agent, an agent may from time to time act as an adjuster and investigate and report upon claims without being required to be licensed as an adjuster.

(b) No license by this state shall be required:

(1) Of a nonresident independent adjuster for the adjustment in this state of a single loss or of losses arising out of a catastrophe common to all such losses; or

(2) Of a nonresident adjuster who regularly adjusts in another state and who is licensed in such other state, if such state requires a license, to act as adjuster in this state for emergency insurance adjustment work for a period not exceeding 60 days and performed for an employer that is an insurance adjuster licensed by this state or that is a regular employer of one or more insurance adjusters licensed by this state, provided that such employer shall furnish to the Commissioner a notice in writing immediately upon the beginning of the emergency insurance adjustment work.

(c) An individual residing in another state may be licensed by the Commissioner as a nonresident adjuster under the following circumstances and in the following manner:

(1) Upon written application and payment of the required license fee and without requiring a written examination, the Commissioner shall issue a license to an individual to act as a nonresident adjuster if the individual is licensed in his or her home state as an adjuster;

(2) The required fee for the license shall be the fee provided by law or the sum which is charged as a license fee for nonresident adjusters by the state of the applicant's residence, whichever is greater; and

(3) Applicants whose home state does not require a license to transact business may be licensed in this state, provided that the applicant takes the examination issued by the Commissioner where required pursuant to this chapter and the applicant submits written documentation from such applicant's resident state demonstrating the lack of licensing requirements in such state and such state's reciprocity with residents of this state.

(d) The Commissioner shall issue a license to an individual to act as a nonresident adjuster if, by the laws of the state of the applicant's residence, residents of this state may be licensed as nonresident adjusters in the same manner.

(e) The Commissioner is authorized to enter into reciprocal agreements with the appropriate official of any other jurisdiction for the purpose of implementing this Code section.

(f) No resident of Canada may be licensed as a nonresident independent adjuster unless such person has obtained a resident or home state independent adjuster license.

Amended by 2019 Ga. Laws 140,§ 12, eff. 7/1/2019.

Amended by 2012 Ga. Laws 776,§ 8, eff. 7/1/2012.

Amended by 2012 Ga. Laws 727,§ 9, eff. 7/1/2012.

Amended by 2008 Ga. Laws 767,§ 16, eff. 7/1/2008.

Amended by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-29.1 - Licensing of nonresident counselors

(a) An individual residing in another state may be licensed by the Commissioner as a nonresident counselor under the following circumstances and in the following manner:

(1) Upon written application and payment of the required license fee and without requiring a written examination, the Commissioner shall issue a license to an individual to act as a nonresident counselor if the individual is licensed in his or her home state as a counselor;

(2) Applicants whose home state does not require a license to transact business as a counselor may be licensed in this state provided that the applicant takes the examination issued by the Commissioner where required pursuant to this chapter and the applicant submits written documentation from the applicant's resident home state demonstrating the lack of a licensing requirement and such state's reciprocity with residents of this state; and

(3) The required fee for the license shall be the fee provided by law or the sum which is charged as a license fee for nonresident counselors by the state of the applicant's residence, whichever is greater.

(b) The Commissioner shall issue a license to an individual to act as a nonresident counselor if, by the laws of the state of the applicant's residence, residents of this state may be licensed as nonresident counselors in the same manner.

(c) The Commissioner is authorized to enter into reciprocal agreements with the appropriate official of any other jurisdiction for the purpose of implementing this Code section.

Amended by 2005 Ga. Laws 19,§ 33, eff. 4/7/2005.

Added by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-30 - Restrictions on signing by agents

An agent shall not sign in blank any policy to be issued outside of such agent's office. An agent shall not give power of attorney to or otherwise authorize anyone to sign the agent's name to policies unless the person so authorized is directly employed by the agent and no other person, and the person has no office files, equipment, or address in regard to the insurance business other than those in the office of the agent. Nothing in this Code section shall prohibit an agent from authorizing an insurer represented by such agent to reproduce mechanically or electronically such agent's signature on policies, certificates, endorsements, riders, or other insurance contract documents.

Amended without change by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-31 - Risk situs; service on nonresidents; venue of action

(a) A risk shall be deemed to have a situs in this state if the insurance is upon or in regard to property having a permanent situs in this state or movable property which is actually in this state or is principally used or kept in this state or on persons resident in this state.

(b) Each nonresident by obtaining a license in this state or by doing business in this state shall be deemed to have consented that any notice provided in this chapter and any summons, notice, or process in connection with any action or proceeding in any state or federal court in this state, which notice, summons, or process grows out of or is based upon any business or acts done or omitted to be done in this state, may be sufficiently served upon such nonresident by serving the same upon the Commissioner. Service shall be made by leaving with the office of the Commissioner a copy of the notice, summons, or process with a fee. The fee for

such service shall be as provided by law. Such service shall be sufficient service upon the nonresident, provided that notice of the service and a copy of the notice, summons, or process shall be immediately sent by registered or certified mail or statutory overnight delivery by the plaintiff or by the Commissioner to the residence of the nonresident addressed to the nonresident. The nonresident's return receipt and the affidavit of compliance with the notice, summons, or process made by the plaintiff or the plaintiff's attorney or by the Commissioner shall be appended to the notice, summons, or process and filed with the case in the court where it is pending or filed with the Commissioner if in regard to a proceeding provided under this chapter. Venue of such an action shall be in the county of the residence of a plaintiff in the action, if the plaintiff resides in this state; otherwise venue shall be in Fulton County. The place of residence of a licensed nonresident placed on file by him or her with the Commissioner shall be deemed to be his or her place of residence until the nonresident places on file with the Commissioner a written notice stating another place of residence. As used in this subsection, the term "process" shall include a petition or complaint attached thereto.

Amended by 2019 Ga. Laws 140,§ 13, eff. 7/1/2019.

Amended by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-32 - Countersigning by resident agents not required generally; exceptions; commissions

Except when required in retaliation pursuant to Code Section 33-3-26, insurance contracts on risks or property located or having a situs in this state need not be countersigned by an agent duly licensed in accordance with Code Section 33-23-5; but, if a licensed nonresident agent participates in the effectuation of such contract and a countersignature is so required, the countersigning agent licensed in accordance with Code Section 33-23-5 shall be entitled to the same commission as allowed by the state of residence of the licensed nonresident but, in any event, to not more than 50 percent of the commission. Nothing contained in this Code section shall be construed to require a company to make additional compensation in the way of commissions or otherwise to a person who is paid on a salary basis.

Amended without change by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-33 - Duty of licensees to provide current information of names and addresses

(a) Every licensee under this chapter shall keep the Commissioner advised of:

(1) The office address of the licensee;

(2) The residence address of the licensee;

(3) The name and address of each insurer that the licensee represents directly or indirectly;

(4) The name and address of each agency of which the licensee is proprietor, partner, officer, director, or employee or which the licensee represents;

(5) Every trade name of such agency; and

(6) The names of all partners and members of any firm or association and the corporate name of any corporation owning or operating such agency as such information changes.

(b) Any change in the information required by subsection (a) of this Code section shall be transmitted to the Commissioner within 30 days of such change on forms prescribed by the Commissioner.

(c) The Commissioner shall prescribe by rule or regulation the form and manner by which such information will be transmitted.

Amended by 2019 Ga. Laws 140,§ 14, eff. 7/1/2019.

Amended by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-34 - Records of transactions

- **(a)** Every agent, limited subagent, counselor, and adjuster under this chapter shall keep at the address as shown on his or her license or at the insurer's regional or home office situated in this state a record of all transactions consummated under such license. The record shall be in organized form and shall include:
  - **(1)** In the case of an agent or limited subagent, a record of each insurance contract procured or issued together with the names of the insurers and insureds, the amount of premium paid or to be paid, and a statement of the subject of the insurance; and the names of any other licensees from whom business is accepted and of persons to whom commissions or allowances of any kind are promised or paid;
  - **(2)** In the case of an adjuster, a record of each investigation or adjustment undertaken or consummated and a statement of any fee, commission, or other compensation received or to be received by the adjuster on account of the investigation or adjustment; and
  - **(3)** Such other and additional information as may be customary or as may be reasonably required by the Commissioner.
- **(b)** All records as to any particular transaction shall be kept for a term of five years beginning immediately after the completion of the transaction or the term of

the contract, whichever is greater, provided that records of losses adjusted by an independent adjuster may be kept at the office of the insurer for whom the adjuster acted.

- **(c)** In the case of agents or limited subagents, the maintaining of the records required by this Code section at the insurance agency licensed under this chapter for which agency the transaction was undertaken shall be deemed to comply with the requirements of subsection (a) of this Code section.

Amended by 2008 Ga. Laws 767,§ 17, eff. 7/1/2008.

Amended without change by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-35 - Reporting and disposition of premiums

- **(a)** An agent, limited subagent, or any other representative of an insurer or of any other person in the effectuation of an insurance contract shall report to the insurer or its agent the premium for the contract and the amount shall be shown in the contract. Each willful violation of this subsection shall constitute a misdemeanor.

- **(b)** All funds representing premiums received or return premiums due the insured by any agent or subagent shall be accounted for in the licensee's fiduciary capacity, shall not be commingled with the licensee's personal funds, and shall be promptly accounted for and paid to the insurer, insured, or agent as entitled to such funds. Nothing contained in this Code section shall be deemed to require any agent or subagent to maintain a separate bank deposit for the funds of each principal, if the funds so held for each principal are reasonably ascertainable from the books of accounts and records of the agent or subagent.

- **(c)** Any violation of this Code section shall constitute grounds or cause for action by the Commissioner, including, but not limited to, probation, suspension, or revocation of the license. Each and every act by a licensee shall also constitute grounds for fines and penalties, which amounts shall be set by rule or regulation of the Commissioner. Any willful violation of this Code section shall constitute a misdemeanor unless such amounts involved exceed $1,000.00, whereby such violation shall constitute a felony.

Amended by 2019 Ga. Laws 140,§ 15, eff. 7/1/2019.

Amended by 2008 Ga. Laws 767,§ 18, eff. 7/1/2008.

Amended without change by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-36 - Inquiry into illegal or improper conduct

The Commissioner may upon his or her own motion and shall upon a written complaint signed by a citizen of this state and filed with the Commissioner inquire into any alleged illegal or improper conduct of any licensee or inquire into the question of whether a licensee is untrustworthy or not competent or not qualified to act as a licensee under this chapter. No finding or decision adverse to any person in regard to whom the inquiry is conducted shall be made by the Commissioner until after notice and hearing as provided in Chapter 2 of this title.

Amended by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-37 - Licensing of surplus lines broker; application; bond; written examination

- **(a)** Nothing in this chapter shall prevent the placing of surplus lines of insurance when authorized and permitted under this title.
- **(b)** Any person, while licensed as a resident agent as to property, casualty, and surety insurance and who is deemed by the Commissioner to be competent and trustworthy, may be licensed as a surplus lines broker as follows:
  - **(1)** Application to the Commissioner for the license shall be on forms furnished by the Commissioner;
  - **(2)** The license fee shall be in an amount as provided in Code Section 33-8-1;
  - **(3)** Each license shall be issued on a biennial basis and shall expire on the last day of the licensee's birth month and may be renewed by filing an application and paying the prescribed fee in accordance with this Code section;
  - **(4)** Prior to the issuance of the license or any renewal of the license, the applicant shall file a bond with the Commissioner or his or her successor in office, for the benefit of any person injured by the violation of the conditions provided in this paragraph. The bond shall be executed by the applicant as principal and by a corporate surety authorized to do business in this state and shall be in the penal sum of $50,000.00, conditioned that the applicant will comply with the following:
    - **(A)** Place insurance only in compliance with Code Section 33-5-25;
    - **(B)** Remit promptly the taxes provided in Code Section 33-5-31;
    - **(C)** Account to any person requesting him or her to obtain insurance for funds or premiums collected in connection with such insurance; and
    - **(D)** Otherwise conduct business in accordance with this title.

The bond shall not be terminated unless prior to such termination 30 days' written notice is filed with the Commissioner; and

- **(5)** Each applicant for a license to act as a surplus lines broker shall submit to a personal written examination to determine his or her competence, unless the applicant is licensed as a surplus lines broker in his or her home state.

Amended by 2019 Ga. Laws 140,§ 16, eff. 7/1/2019.

Amended by 2012 Ga. Laws 419,§ 3, eff. 3/22/2012.

Amended by 2011 Ga. Laws 220,§ 4, eff. 5/12/2011.

Amended by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-38 - Placing insurance beyond scope of license or with nonlicensed insurers prohibited; restrictions on sharing commissions; penalty for violation

- **(a)** No agent or limited subagent shall place any insurance or receive any remuneration in regard to any insurance of a classification outside the scope of such agent's or limited subagent's license, nor shall the agent or limited subagent share a commission except with an agent licensed pursuant to this article; with an agency that has as its proprietor or as a partner in the agency or as an officer or employee of the agency one or more agents licensed in regard to insurance that is within the scope of his or her agency; or with an agent or agency having a residence or situs in another state and a license from such other state for the transaction of insurance in that state.
- **(b)** Except as otherwise provided in this title, no person shall solicit or be instrumental in placing insurance upon any risk having a situs in this state except with an insurer admitted to do insurance business in this state.
- **(c)** A violation of this Code section shall authorize, among other penalties, the revocation of the violator's license as an agent or subagent.

Amended by 2008 Ga. Laws 767,§ 19, eff. 7/1/2008.

Amended without change by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-39 - Placing of insurance through unlicensed agent prohibited; exception relating to construction project bid bonds

No insurer shall issue, make, write, place, or cause to be made, written, placed, or issued any contract of insurance, indemnity, or suretyship covering risks or property located or having a situs in this state or covering any liability created by or arising under the laws of this state, except through an agent or agents licensed pursuant to this article, except that bid bonds issued by any surety insurer in

connection with any public or private building or construction project may be issued without regard to this Code section or as provided for in subparagraph (h)(2)(F) of Code Section 33-23-4.

Amended by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-40 - Contracts issued by unauthorized persons not rendered unenforceable

Any contract of insurance issued by a person prohibited by this chapter from so issuing it shall not be rendered unenforceable by reason of the violation of this chapter, but all persons knowingly participating in the violation shall be subject to the provisions of Chapter 2 of this title.

Amended by 2019 Ga. Laws 140,§ 17, eff. 7/1/2019.

Amended without change by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-41 - Liability and penalties for unauthorized acts

Any person who in this state acts, purports to act, or holds himself or herself out as an agent, limited subagent, counselor, or adjuster or as an employee of an agent, limited subagent, counselor, or adjuster of or for an insurer that has not obtained from the Commissioner a certificate of authority then in effect to do business in this state as required by this article or who has not obtained a certificate of authority as required by this article and any person who in this state collects or forwards any premium or portion of the premium for or to the insurer shall pay a sum equal to the state, county, and municipal taxes and license fees required to be paid by the insurance companies legally doing business in this state. It is the Commissioner's duty to report violators of this Code section to the district attorney for the county in which the violations occurred. Violators of this Code section shall also be personally liable to the same extent as the insurer upon every contract of insurance made by the insurer with reference to a risk having a situs in this state, if the violator participated in the solicitation, negotiation, or making of the contract or in any endorsement to the contract, in any modification of the contract, or in the collection or forwarding of any premium or portion of the premium relating to such contract. This Code section shall have no application to a contract of insurance entered into in accordance with Chapter 5 of this title.

Amended by 2019 Ga. Laws 140,§ 18, eff. 7/1/2019.

Amended by 2008 Ga. Laws 767,§ 20, eff. 7/1/2008.

Amended by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-42 - Performing acts for unauthorized insurer

Any person who performs any of the acts or things specified in this chapter for any insurance company or agent of said company without such company's having first received a certificate of authority from the Commissioner as required by law shall be punished as for a misdemeanor and shall also pay a sum equal to the state, county, and municipal taxes and license fees required to be paid by insurance companies legally doing business in this state. It shall be the duty of the Commissioner to report any violation of this Code section to the district attorney or prosecuting attorney of the circuit or county which has jurisdiction.

Amended without change by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-43 - Authority of adjusters; penalty for violation

- **(a)** An adjuster licensed as both an independent and a public adjuster shall not represent both the insurer and the insured in the same transaction.
- **(b)** An adjuster shall have authority under his or her license only to investigate, settle, or adjust and report to his or her principal upon claims arising under insurance contracts on behalf of insurers only if licensed as an independent adjuster or on behalf of insureds only if licensed as a public adjuster.
- **(c)** No public adjuster, at any time, shall knowingly:
  - **(1)** Misrepresent to an insured that he or she is required to hire an independent or public adjuster to help the insured meet his or her obligations under his or her policy;
  - **(2)** Accept or agree to accept any money or other compensation from an attorney or any person acting on behalf of an attorney which the adjuster knows or should reasonably know is payment for the suggestion or advice by the adjuster to seek the services of the attorney or for the referral of any portion of a person's claim to the attorney;
  - **(3)** Hire or procure another to do any act prohibited by this subsection;
  - **(4)** Advertise or promise to pay or rebate all or any portion of any insurance deductible as an inducement to the sale of goods or services. As used in this paragraph, the term "promise to pay or rebate" includes:
    - **(A)** Granting any allowance or offering any discount against the fees to be charged, including, but not limited to, an allowance or discount in return for displaying a sign or other advertisement at the insured's premises; or
    - **(B)** Paying the insured or any person directly or indirectly associated with the claim any form of compensation, gift, prize, bonus, coupon, credit, referral fee, or other item of monetary value for any reason;

- **(5)** Misrepresent to a claimant that he or she is an adjuster representing an insurer in any capacity, including acting as an employee of the insurer or as an independent adjuster, unless appointed by an insurer in writing to act on the insurer's behalf for that specific claim or purpose. A licensed public adjuster shall not charge a claimant a fee for adjusting a claim when he or she is appointed by the insurer for that specific claim or purpose and the appointment is accepted by the public adjuster;
- **(6)** Solicit, or attempt to solicit, an insured during the progress of a loss-producing occurrence as defined in the insured's insurance contract;
- **(7)** Have a direct or indirect financial interest in any aspect of a claim other than the salary, fee, commission, or other consideration established in a written contract with the insured which shall incorporate all of the conditions and provisions set out in Code Section 33-23-43.2;
- **(8)** Charge to or collect from an insured any amount, other than reasonable compensation for services rendered based on time spent and expenses incurred, in any transaction where the insurer either pays or commits in writing to pay the policy limit or limits for all coverage under the insured's policy within three business days after the loss is reported to the insurer;
- **(9)** Misrepresent to an insured or insurer that he or she is an attorney authorized by law to provide legal advice and services or that a policy covers a loss or losses outside the scope of the coverage provided by the insurance contract;
- **(10)** Permit an unlicensed employee or representative of the adjuster to conduct business for which a license is required; or
- **(11)** Hire or procure another to do any act prohibited by this subsection.

- **(d)** For purposes of subsection (c) of this Code section, the term "public adjuster" shall include licensed public adjusters as defined by Code Section 33-23-1, persons representing themselves to be public adjusters who are not properly licensed by the Commissioner, and persons committing any act under paragraph (4) of subsection (c) of this Code section.
- **(e)** Any person who violates any provision of subsection (c) of this Code section shall be guilty of a misdemeanor and such violation shall be grounds for suspension or revocation of licenses under this chapter.
- **(f)** The Commissioner may adopt reasonable and necessary rules to implement this article, including but not limited to rules regarding:

- **(1)** The qualifications for adjusters, in addition to those prescribed by this article, that are necessary to promote the public interest;
- **(2)** The regulation of the conduct of adjusters, in accord with this article;
- **(3)** The prescription of fees not prescribed elsewhere in this title that are necessary to cover the cost of filings or other administrative costs; and
- **(4)** The regulation of advertisements and the definition of "advertisement" as the term is used in paragraph (4) of subsection (c) of this Code section.

Amended by 2021 Ga. Laws 185,§ 1, eff. 7/1/2021.

Amended by 2019 Ga. Laws 140,§ 19, eff. 7/1/2019.

Amended by 2015 Ga. Laws 9,§ 33, eff. 3/13/2015.

Amended by 2014 Ga. Laws 504,§ 4, eff. 7/1/2014.

Amended by 2011 Ga. Laws 201,§ 2, eff. 7/1/2011.

Amended by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-43.1 - Representing oneself as public adjuster; when license not required

- **(a)** No person may act or hold himself or herself out to be a public adjuster in this state unless such person holds a public adjuster license issued by the Commissioner.
- **(b)** A public adjuster license is not, however, required for:
  - **(1)** An attorney licensed to practice law in this state while acting for an insured concerning a loss under a policy; or
  - **(2)** A person licensed as a general property and casualty agent or personal lines property and casualty agent while acting for an insurer concerning a loss under a policy issued by that agent.

Added by 2021 Ga. Laws 185,§ 2, eff. 7/1/2021.

Renumbered as § 33-23-43.2 and amended by 2021 Ga. Laws 185,§ 3, eff. 7/1/2021

Section 33-23-43.2 - Requirements for public adjuster contracts

- **(a)** No person may, directly or indirectly, act within this state as a public adjuster without, among other requirements, having first entered into a contract, in writing, on a form approved by the Commissioner, executed in duplicate by such person and the insured or the insured's duly authorized representative. A public

adjuster shall not use any form of contract that is not approved by the Commissioner.

- **(b)** Public adjusters shall ensure that all contracts for their services are in writing, prominently captioned and titled "Public Adjuster Contract," and contain the following:
  - **(1)** Legible full name of the public adjuster signing the contract, as specified on the license issued by the department and attestation language that the public adjuster is fully bonded pursuant to state law;
  - **(2)** Permanent home state business address and contact information of the public adjuster, including email address;
  - **(3)** The public adjuster's department license number and a statement that the license is valid and in full force and effect as of the date the contract is signed;
  - **(4)** The insured's full name and street address;
  - **(5)** A description of the loss and its location, if applicable;
  - **(6)** A description of services to be provided to the insured;
  - **(7)** Signatures of the public adjuster and the insured;
  - **(8)** The date the contract was signed by the public adjuster, and the date the contract was signed by the insured;
  - **(9)** A statement of the fee, compensation, or other considerations that the public adjuster is to receive for services, including a listing of typical costs and expenses for which the public adjuster is to be reimbursed;
  - **(10)** A statement prominently captioned in a minimum 12 point font indicating that the public adjuster has no direct or indirect interest, including participation in activities that may be reasonably construed as a conflict of interest or as compensation by or interest in, any firm that performs any work in conjunction with the damages incident to any loss the public adjuster has been contracted to adjust, except for the compensation or fee from the insured for such public adjuster's services; and
  - **(11)** A prominently displayed notice in 12-point boldface type that states "WE REPRESENT THE INSURED ONLY."
- **(c)** Public adjuster contracts may not contain a contract term that:

- **(1)** Restricts an insured's right to initiate and maintain direct communications with his or her attorney, the insurer, the insurer's adjuster, the insurer's attorney, or any other person regarding settlement of the insured's claim;
- **(2)** Vests the public adjuster with the right to initiate direct communications with the insured's insurer, the insurer's adjuster, or the insurer's attorney regarding settlement of the insured's claim without specific written authorization from the insured;
- **(3)** Allows the public adjuster's percentage fee to be collected when money is due from an insurance company but not paid or that allows a public adjuster to collect the entire fee from the first check issued by an insurance company rather than as a percentage of each check issued by an insurance company;
- **(4)** Requires the insured to authorize an insurance company to issue a check only in the name of the public adjuster;
- **(5)** Precludes or restricts an insured from pursuing any civil remedies relating to his or her claim;
- **(6)** Purports to allow the public adjuster to act in multiple capacities; or
- **(7)** Identifies the public adjuster as also being a contractor, appraiser, or other position.

- **(d)** All public adjuster contracts shall be construed to contain, by operation of law:
  - **(1)** A provision granting the insured a right to rescind the contract within three business days after the date the contract was signed, so long as the rescission is in writing and mailed or delivered to the public adjuster at the address stated in the contract within three business days. For purposes of this subsection, rescission of the contract shall be considered delivered or mailed if it is delivered by electronic transmittal to the email address or facsimile specified in the contract for such communications;
  - **(2)** A provision that if the insured exercises the right to rescind the contract, anything of value given by the insured under the contract shall be returned to the insured within 15 business days following the receipt by the public adjuster of the rescission notice; and
  - **(3)** A provision requiring that, prior to initiating any contact with the insured's insurer, the insurer's adjuster, or the insurer's attorney regarding settlement of the insured's claim, a public adjuster must provide the insurer a

notification letter signed by the insured confirming that the insured has authorized the public adjuster to communicate directly with the insurer, the insurer's adjuster, or the insurer's attorney on behalf of the insured.

- **(e)** All public adjuster contracts shall be executed in duplicate to provide an original contract to the public adjuster and an original contract to the insured. The public adjuster's original contract shall be available at all times for inspection without notice by the department.

- **(f)** No public adjuster shall enter into a contract with an insured and collect a commission as provided by Code Section 33-23-43.3, without having the intent to actually perform services customarily provided by a public adjuster for the insured.

Amended by 2023 Ga. Laws 265,§ 4, eff. 5/3/2023.

Renumbered from § 33-23-43.1 and amended by 2021 Ga. Laws 185,§ 3, eff. 7/1/2021.

Amended by 2020 Ga. Laws 521,§ 33, eff. 7/29/2020.

Amended by 2019 Ga. Laws 140,§ 20, eff. 7/1/2019.

Amended by 2015 Ga. Laws 9,§ 33, eff. 3/13/2015.

Added by 2014 Ga. Laws 504,§ 5, eff. 7/1/2014.

Renumbered as § 33-23-43.9 and amended by 2021 Ga. Laws 185,§ 5, eff. 7/1/2021

Section 33-23-43.3 - Compensation of adjusters; criteria for written endorsement of payment

- **(a)** Except as provided by subsection (b) of this Code section, an adjuster may receive a commission for service provided under this article consisting of an hourly fee, a flat rate, a percentage of the total amount paid by an insurer to resolve a claim, or another method of compensation. A public adjuster may not charge the insured an unreasonable fee, and the total commission received shall not exceed 33.3 percent of the amount of the insurance settlement of the claim.

- **(b)** An adjuster shall not receive a commission consisting of a percentage of the total amount paid by an insurer to resolve a claim on a claim on which the insurer, not later than 72 hours after the date on which the loss is reported to the insurer, either pays or commits in writing to pay to the insured the policy limit of the insurance policy. A public adjuster is entitled to reasonable compensation from the insured for services provided by such adjuster on behalf of the insured, based on the time spent on a claim that is subject to this Code section and expenses incurred by such adjuster, until the claim is paid or the insured receives a written commitment to pay from the insurer.

- **(c)** Except for the payment of a commission by the insured, all persons paying proceeds of a policy of insurance or making any payment affecting an insured's rights under a policy of insurance shall:
  - **(1)** Include the insured as a payee on the payment draft or check; and
  - **(2)** Require the written signature and endorsement of the insured on the payment draft or check.
- **(d)** An adjuster shall not accept any payment that violates the provisions of this Code section.
- **(e)** A public adjuster may sign or endorse a payment, draft, or check issued on behalf of an insured if authorized in writing by each insured payee, and only if such written endorsement meets the following criteria:
  - **(1)** The authorization limits the public adjuster to endorse the check or payment for deposit only into the public adjuster's escrow or trust account and such authorization states that the check or payment will be distributed in the percentages or amounts agreed upon in the public adjuster contract;
  - **(2)** The authorization requires that the insured be notified of the deposit of funds, and states that any distribution of such funds to the insured or the public adjuster will be accompanied by a detailed breakdown of the funds distributed; and
  - **(3)** The authorization form states that such authorization may be revoked at any time by the insured upon written notice of such revocation to the public adjuster.

Added by 2021 Ga. Laws 185,§ 4, eff. 7/1/2021.

Section 33-23-43.4 - Proof of financial responsibility

- **(a)** As a continuing condition of licensure, a public adjuster may, at the Commissioner's discretion, file proof of financial responsibility with respect to transactions with insureds under this chapter in an amount determined by the Commissioner by rule. The financial responsibility shall include the ability to pay sums that the public adjuster is obligated to pay under any judgment against such adjuster by an insured, based on an error, omission, fraud, negligent act, or unfair practice of such adjuster or any person for whose acts such adjuster is legally liable in the transaction of such adjuster's business under this Code section.
- **(b)** In determining the amount of the financial responsibility requirement, the Commissioner shall consider the nature of the obligation, other financial security requirements under this Code section, and financial security requirements adopted

for public adjusters in other states. In determining the types of financial responsibility required, the Commissioner may consider a surety bond or a professional liability policy or similar policy or contract of professional liability coverage acceptable to the Commissioner.

- **(c)** The requirements of this Code section are in addition to the bond requirements of Code Section 33-23-6 and relevant rules and regulations promulgated by the Commissioner.

Added by 2021 Ga. Laws 185,§ 4, eff. 7/1/2021.

Section 33-23-43.5 - Complete record of transactions; retention and examination

- **(a)** A public adjuster shall keep a complete record in this state of each of such adjuster's transactions as a public adjuster. The records shall include each of the following:
  - **(1)** The name of the insured;
  - **(2)** The date, location, and amount of the loss;
  - **(3)** A copy of the contract between the public adjuster and the insured;
  - **(4)** The name of the insurer and the amount, expiration date, and number of each policy under which the loss is covered;
  - **(5)** An itemized statement of the recoveries by the insured from the sources known to the public adjuster;
  - **(6)** The total compensation received for the adjustment; and
  - **(7)** An itemized statement of disbursements made by the license holder from recoveries received on behalf of the insured.
- **(b)** Records required to be kept under this Code section shall be:
  - **(1)** Maintained in this state for at least five years after the termination of a transaction with the insured; and
  - **(2)** Open to examination by the Commissioner.

Added by 2021 Ga. Laws 185,§ 4, eff. 7/1/2021.

Section 33-23-43.6 - Funds held in fiduciary capacity; authorization for disclosure

- **(a)** All funds received as claim proceeds by an adjuster acting as a public adjuster are received and held by such adjuster in a fiduciary capacity. Such adjuster shall not divert or misappropriate fiduciary funds received or held.
- **(b)** An applicant for a license to act as a public adjuster shall, as part of the application, endorse an authorization for disclosure to the Commissioner of all

financial records of any funds such adjuster holds and will hold as a fiduciary. The authorization continues in force and effect for as long as such adjuster continues to be licensed under this article.

Added by 2021 Ga. Laws 185,§ 4, eff. 7/1/2021.

Section 33-23-43.7 - Advertisements; deceptive or misleading ads; required disclaimer

- **(a)** Each advertisement by an adjuster soliciting or advertising business shall display the adjuster's name and license number as they appear in the records of the Commissioner.
- **(b)** No advertisement soliciting or advertising business may be used by an adjuster unless such solicitation or advertisement has been approved by the Commissioner.
- **(c)** The following statements, made in any public adjuster's advertisement or solicitation, are considered deceptive or misleading:
  - **(1)** A statement or representation that invites an insured to submit a claim when such insured does not have covered damage to such insured's property;
  - **(2)** A statement or representation that invites an insured to submit a claim by offering monetary or other valuable inducement;
  - **(3)** A statement or representation that invites an insured to submit a claim by stating that there is "no risk" to the insured by submitting such claim; and
  - **(4)** A statement or representation, or use of a logo or shield, that implies or could mistakenly be construed to imply that the solicitation was issued or distributed by a governmental agency or is sanctioned or endorsed by a governmental agency.
- **(d)** For purposes of this subsection, the term "written advertisement" includes only newspapers, magazines, flyers, and bulk mailers. The following disclaimer, which is not required to be printed on standard size business cards, shall be added in bold print and capital letters in typeface no smaller than the typeface of the body of the text to all written advertisements of a public adjuster:

"THIS IS A SOLICITATION FOR BUSINESS. IF YOU HAVE HAD A CLAIM FOR AN INSURED PROPERTY LOSS OR DAMAGE AND YOU ARE SATISFIED WITH THE PAYMENT BY YOUR INSURER, YOU MAY DISREGARD THIS ADVERTISEMENT".

Added by 2021 Ga. Laws 185,§ 4, eff. 7/1/2021.

Section 33-23-43.8 - Prohibited acts of adjusters

- **(a)** An adjuster shall not solicit or attempt to solicit a client for employment during the progress of a loss-producing natural disaster occurrence. For purposes of this subsection, the term "natural disaster" means any natural disaster for which a state of emergency is proclaimed by the Governor.
- **(b)** An adjuster shall not solicit or attempt to solicit business on a loss or a claim in person, by telephone, or in any other manner at any time except between the hours of 8:00 A.M. and 10:00 P.M. on a weekday or a Saturday and between noon and 10:00 P.M. on a Sunday. This subsection shall not prohibit an adjuster from accepting phone calls or personal visits during the prohibited hours from an insured on the insured's initiation.
- **(c)** An adjuster shall not knowingly make any false report to the adjuster's employer or client and shall not divulge to any other person, except as the law may require, any information obtained except at the direction of the employer or the client for whom the information is obtained.
- **(d)** An adjuster shall not permit an unlicensed employee or other representative of the adjuster to in any manner conduct business for which a license is required under this chapter.
- **(e)** An agent shall not render services or perform acts that constitute the practice of law, including the giving of legal advice to any person, in his or her capacity as an adjuster.
- **(f)** A public adjuster shall not solicit or attempt to solicit business, directly or indirectly, or act in any manner on a bodily injury loss covered by a life, health, or accident insurance policy or on any claim for which the client is not an insured under the insurance policy.
- **(g)** An adjuster shall not:
  - **(1)** Participate directly or indirectly in the reconstruction, repair, or restoration of damaged property that is the subject of a claim adjusted by such adjuster;
  - **(2)** Engage in any other activities that may reasonably be construed as presenting a conflict of interest, including soliciting or accepting any remuneration from, having a financial interest in, or deriving any direct or indirect financial benefit from, any salvage firm, repair firm, construction firm, or other firm that obtains business in connection with any claim the adjuster has a contract or agreement to adjust;

- **(3)** Without the knowledge and consent of the insured in writing, acquire an interest in salvaged property that is the subject of a claim adjusted by such adjuster;
- **(4)** Represent an insured on a claim or charge a fee to an insured while representing the insurance carrier against which such claim is made;
- **(5)** Directly or indirectly solicit employment for an attorney or enter into a contract with an insured for the primary purpose of referring an insured to an attorney without the intent to actually perform the services customarily provided by a licensed public adjuster. This Code section shall not be construed to prohibit an adjuster from recommending a particular attorney to an insured; or
- **(6)** Act on behalf of an attorney during the course of a claim adjustment, through an insured signed attorney representation agreement or other means.

- **(h)** An adjuster shall not engage in misrepresentation to solicit a contract or agreement to adjust a claim.
- **(i)** An adjuster shall not:
  - **(1)** Advance money to any potential client or insured; or
  - **(2)** Pay, allow, or give, or offer to pay, allow, or give, directly or indirectly, to a person who is not a licensed public adjuster a fee, commission, or other valuable consideration for the referral of an insured to such adjuster for purposes of the insured entering into a contract with such adjuster or for any related purpose.
- **(j)** An adjuster shall not use any letterhead, advertisement, or other printed matter, or use any other means, to represent that such adjuster is an instrumentality of the federal government, of a state, or of a political subdivision of a state.
- **(k)** A contractor shall not act as a public adjuster or advertise to adjust claims for any property for which the contractor is providing or may provide contracting services, regardless of whether the contractor:
  - **(1)** Holds a license under this chapter; or
  - **(2)** Is authorized to act on behalf of the insured under a power of attorney or other agreement. However, a contractor may discuss or explain a bid for construction or repair of covered property with a residential property owner who has suffered loss or damage covered by a property insurance policy, or the insurer of such property, if the contractor is doing so for the usual and customary

fees applicable to the work to be performed as stated in the contract between the contractor and the insured.

- **(l)** A public adjuster shall not accept a fee, commission, or other valuable consideration of any nature, regardless of form or amount, in exchange for the referral by such adjuster of an insured to any third-party individual or firm, including an attorney, appraiser, umpire, construction company, contractor, or salvage company.

- **(m)** No person who has had his or her license under this title refused or revoked shall be an owner, officer, or director of a business entity, association, or corporation if such entity, association, or corporation holds itself out as a public adjuster, a public adjusting firm, or otherwise represents itself or acts as an association of public adjusters or an association which offers public adjusting services.

Amended by 2022 Ga. Laws 782,§ 33, eff. 5/2/2022.

Added by 2021 Ga. Laws 185,§ 4, eff. 7/1/2021.

Section 33-23-43.9 - Standard of conduct for public adjusters

- **(a)** A public adjuster is obligated, under his or her license, to serve with objectivity and complete loyalty to the interest of his or her client alone and to render to the insured such information, counsel, and service within the public adjuster's knowledge, understanding, and opinion that will best serve the insured's insurance claim needs and interest.

- **(b)** A public adjuster shall faithfully observe all of the terms and provisions of the public adjuster contract as prescribed in Code Section 33-23-43.2.

Renumbered from § 33-23-43.2 and amended by 2021 Ga. Laws 185,§ 5, eff. 7/1/2021.

Added by 2014 Ga. Laws 504,§ 5, eff. 7/1/2014.

Section 33-23-43.10 - Denial, suspension, or revocation of license; notice and hearing

- **(a)** The Commissioner may deny an application for a license or suspend or revoke a license issued to any public adjuster on the basis of:

  - **(1)** A violation of this article or of any rule adopted by the Commissioner under this article;

  - **(2)** A cause that constitutes grounds for denial of an original license;

  - **(3)** Misrepresentation or fraud in obtaining a license;

  - **(4)** The failure to pass a required license examination;

- **(5)** The misappropriation or conversion of money required to be held in a fiduciary capacity;
- **(6)** Material misrepresentation, with intent to deceive, of the terms of an insurance contract;
- **(7)** Engaging in a fraudulent transaction;
- **(8)** Demonstrating incompetence or untrustworthiness in the conduct of the license holder's affairs under the license, as determined by the Commissioner;
- **(9)** Conviction of a felony by a final judgment in a court of competent jurisdiction; or
- **(10)** Material misrepresentation, with intent to deceive, of the person's status as a public adjuster.

- **(b)** If the department proposes to refuse to issue an original license under this article or to suspend, revoke, or refuse to renew a license under this article, the rejected applicant or affected licensee is entitled to a notice and hearing in accordance with Chapter 2 of this title.

Added by 2021 Ga. Laws 185,§ 6, eff. 7/1/2021.

Section 33-23-44 - Rules and regulations

- **(a)** The Commissioner may establish rules and regulations with respect to:
  - **(1)** The classification of applicants according to the kinds of insurance to be effected by them if licensed;
  - **(2)** The scope, type, and conduct of written examinations to be given pursuant to this chapter and the times and places within this state for holding the examinations;
  - **(3)** Classification and scope of authority of any license authorized under this chapter; and
  - **(4)** Any other purpose required or necessary for the implementation or enforcement of this chapter.
- **(b)** The Commissioner shall establish by rule or regulation a license for persons exempted under Code Section 33-23-18 that is distinct from other agent licenses.

Amended without change by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-45 - [Reserved] Limitation on applicability of article

Amended by 2019 Ga. Laws 140,§ 21, eff. 7/1/2019.

Amended by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Section 33-23-46 - Compensation of licensed counselors; disclosure; exceptions

- **(a)** For purposes of this Code section, the term:
  - **(1)** "Affiliate" means a person that controls, is controlled by, or is under common control with the producer.
  - **(2)** "Compensation from an insurer or other third party" means payments, commissions, fees, awards, overrides, bonuses, contingent commissions, loans, stock options, gifts, prizes, or any other form of valuable consideration, whether or not payable pursuant to a written agreement, but shall not mean de minimis gifts of less than $45.00 in value.
  - **(3)** "Compensation from the customer" shall not include:
    - **(A)** Any fee or similar expense provided in subparagraph (C) of paragraph (6) of Code Section 33-6-5;
    - **(B)** Any amount or fee paid by or to the producer that does not exceed an amount established by the Commissioner; or
    - **(C)** A premium or fee billed by the producer solely on behalf of an insurer.
  - **(4)** "Documented acknowledgment" means the customer's written consent obtained prior to the customer's initial purchase of insurance. In the case of a purchase over the telephone or by electronic means for which written consent cannot reasonably be obtained, consent documented by the producer shall be acceptable.
- **(b)**
  - **(1)** Where any insurance producer licensed as counselor, as defined by this chapter, or any affiliate of such producer receives any compensation from or charges any other fee to the customer, neither that producer nor the affiliate shall accept or receive any compensation from an insurer or other third party for placement of insurance for that customer unless the producer has, prior to the customer's purchase of insurance:
    - **(A)** Obtained the customer's documented acknowledgment that such compensation will be received by the producer or affiliate; and
    - **(B)** Disclosed the amount of compensation from the insurer or other third party for that placement. If the amount of compensation is not known at the time of disclosure, the producer shall disclose in readable language the method for calculating such compensation and, if possible, a reasonable estimate of the amount.
  - **(2)** Notwithstanding paragraph (1) of this subsection, an insurance producer who is not licensed as a counselor, as defined in this chapter, may not accept or receive any compensation from the customer for placement of insurance.

- **(c)** A person shall not be considered a customer for purposes of this Code section if the person is merely:
  - **(1)** A participant or beneficiary of an employee benefit plan; or
  - **(2)** Covered by a group or blanket insurance policy or group annuity contract sold, solicited, or negotiated by the insurance producer or affiliate.
- **(d)** This Code section shall not apply to:
  - **(1)** A person licensed as an insurance producer who acts only as an intermediary between an insurer and the producer, such as a managing general agent, a sales manager, or a wholesale broker;
  - **(2)** A reinsurance intermediary;
  - **(3)** The renewal or any other continuation of the policy; or
  - **(4)** A producer whose sole compensation for the placement is derived from commissions, salaries, and other remuneration from the insurer.
- **(e)** The Commissioner may promulgate rules and regulations as necessary to implement the provisions of this Code section.

Added by 2005 Ga. Laws 108,§ 6, eff. 7/1/2005.

Article 2 - LICENSING OF ADMINISTRATORS (§§ 33-23-100 — 33-23-105)

Section 33-23-100 - Definitions; exemptions; applicability of Code Sections 33-24-59.5 and 33-24-59.14

- **(a)** As used in this article, the term:
  - **(1)** "Administrator" means any business entity that, directly or indirectly, collects charges, fees, or premiums; adjusts or settles claims, including investigating or examining claims or receiving, disbursing, handling, or otherwise being responsible for claim funds; or provides underwriting or precertification and preauthorization of hospitalizations or medical treatments for residents of this state for or on behalf of any insurer, including business entities that act on behalf of a single or multiple employer self-insurance health plan or a self-insured municipality or other political subdivision. Licensure is also required for administrators who act on behalf of self-insured plans providing workers' compensation benefits pursuant to Chapter 9 of Title 34. For purposes of this article, each activity undertaken by the administrator on behalf of an insurer or the client of the administrator is considered a transaction and is subject to the provisions of this title.

- **(2)** "Business entity" means a corporation, association, partnership, sole proprietorship, limited liability company, limited liability partnership, or other legal entity.
- **(3)** "Standard financial quarter" means a three-month period ending on March 31, June 30, September 30, or December 31 of any calendar year.

- **(b)** Notwithstanding the provisions of subsection (a) of this Code section, the following are exempt from licensure so long as such entities are acting directly through their officers and employees:
- **(1)** An employer on behalf of its employees or the employees of one or more subsidiary or affiliated corporations of such employer;
- **(2)** A union on behalf of its members;
- **(3)** An insurance company licensed in this state or its affiliate unless the affiliate administrator is placing business with a nonaffiliate insurer not licensed in this state;
- **(4)** An insurer which is not authorized to transact insurance in this state if such insurer is administering a policy lawfully issued by it in and pursuant to the laws of a state in which it is authorized to transact insurance;
- **(5)** A life or accident and sickness insurance agent or broker licensed in this state whose activities are limited exclusively to the sale of insurance;
- **(6)** A creditor on behalf of its debtors with respect to insurance covering a debt between the creditor and its debtors;
- **(7)** A trust established in conformity with 29 U.S.C. Section 186 and its trustees, agents, and employees acting thereunder;
- **(8)** A trust exempt from taxation under Section 501(a) of the Internal Revenue Code and its trustees and employees acting thereunder or a custodian and its agents and employees acting pursuant to a custodian account which meets the requirements of Section 401(f) of the Internal Revenue Code;
- **(9)** A bank, credit union, or other financial institution which is subject to supervision or examination by federal or state banking authorities;
- **(10)** A credit card issuing company which advances for and collects premiums or charges from its credit card holders who have authorized it to do so, provided that such company does not adjust or settle claims;
- **(11)** A person who adjusts or settles claims in the normal course of his or her practice or employment as an attorney and who does not collect charges or

premiums in connection with life or accident and sickness insurance coverage or annuities;

- **(12)** An insurance company licensed in this state or its affiliate if such insurance company or its affiliate is solely administering limited benefit insurance. For the purpose of this paragraph, the term "limited benefit insurance" means accident or sickness insurance designed, advertised, and marketed to supplement major medical insurance and specifically shall include accident only, CHAMPUS supplement, disability income, fixed indemnity, long-term care, or specified disease insurance; or
- **(13)** An association that administers workers' compensation claims solely on behalf of its members.

- **(c)** A business entity claiming an exemption shall submit an exemption notice on a form provided by the Commissioner. This form must be signed by an officer of the company and submitted to the department by December 31 of the year prior to the year for which an exemption is to be claimed. Such exemption notice shall be updated in writing within 30 days if the basis for such exemption changes. An administrator claiming an exemption pursuant to paragraphs (3) and (4) of subsection (b) of this Code section shall be subject to the provisions of Code Sections 33-24-59.5 and 33-24-59.14.
- **(d)** Obtaining a license as an administrator does not exempt the applicant from other licensing requirements under this title.
- **(e)** Obtaining a license as an administrator subjects the applicant to the provisions of Code Sections 33-24-59.5 and 33-24-59.14.
- **(f)** An administrator shall be subject to Code Sections 33-24-59.5 and 33-24-59.14 unless the administrator provides sufficient evidence that the self-insured health plan failed to properly fund the plan to allow the administrator to pay any outside claim.

Amended by 2011 Ga. Laws 196,§; 4, eff. 1/1/2013.

Amended by 2005 Ga. Laws 108,§; 7, eff. 7/1/2005.

Section 33-23-101 - Licensing of administrators; filing fee; refusal, suspension, or revocation of license; notice and hearing; reissuance of revoked license; appeal; probationary licenses; additional qualifications for license; restrictions on licensees; penalties

- **(a)** No business entity shall act as or hold itself out to be an administrator in this state, other than an adjuster licensed in this state for the kinds of business for

which it is acting as an administrator, unless such business entity holds a license as an administrator issued by the Commissioner. The license shall be renewed on an annual basis and in such manner as the Commissioner may prescribe by rule or regulation. Failure to hold such license shall subject the administrator to the fines and other appropriate penalties as provided in Chapter 2 of this title.

- **(b)** An application for an administrator's license or an application for renewal of such license shall be accompanied by a filing fee to be prescribed by rule or regulation of the Commissioner.

- **(c)** A license may be refused or a license duly issued may be suspended or revoked or the renewal of such license refused by the Commissioner if the Commissioner finds that the applicant for or holder of the license:

  - **(1)** Has violated any provision of this title or of any other law of this state relating to insurance as defined in this chapter or relating to another type of insurance;

  - **(2)** Has intentionally misrepresented or concealed any material fact in the application for the license;

  - **(3)** Has obtained or attempted to obtain the license by misrepresentation, concealment, or other fraud;

  - **(4)** Has misappropriated, converted to his or her own use, or illegally withheld money belonging to an insurer or an insured or beneficiary;

  - **(5)** Has committed fraudulent or dishonest practices;

  - **(6)** Has materially misrepresented the terms and conditions of insurance policies or contracts;

  - **(7)** Has failed to comply with or has violated any proper order, rule, or regulation issued by the Commissioner;

  - **(8)** Is not in good faith carrying on business as an administrator;

  - **(9)** Has failed to obtain for initial licensure or retain for annual renewal an adequate net worth as prescribed by order, rule, or regulation of the Commissioner; or

  - **(10)** Has shown lack of trustworthiness or lack of competence to act as an administrator.

- **(d)** If the Commissioner moves to suspend, revoke, or nonrenew a license for an administrator, the Commissioner shall provide notice of that action to the

administrator and the administrator may invoke the right to an administrative hearing in accordance with Chapter 2 of this title.

- **(e)** No licensee whose license has been revoked as prescribed under this Code section shall be entitled to file another application for a license within five years from the effective date of the revocation or, if judicial review of such revocation is sought, within five years from the date of final court order or decree affirming the revocation. The application when filed may be refused by the Commissioner unless the applicant shows good cause why the revocation of its license shall not be deemed a bar to the issuance of a new license.

- **(f)** Appeal from any order or decision of the Commissioner made pursuant to this article shall be taken as provided in Chapter 2 of this title.

- **(g)**

  - **(1)** The Commissioner shall have the authority to issue a probationary license to any applicant under this article.

  - **(2)** A probationary license may be issued for a period of not less than three months and not longer than 12 months and shall be subject to immediate revocation for cause at any time without a hearing.

  - **(3)** The Commissioner, at his or her discretion, shall prescribe the terms of probation, may extend the probationary period, or refuse to grant a license at the end of any probationary period.

- **(h)** The Commissioner may impose, by rule or regulation, additional reasonable qualifications necessary to obtain a license as an administrator.

- **(i)** An administrator's license may not be sold or transferred to a nonaffiliated or otherwise unrelated party. An administrator may not contract or subcontract any of its negotiated services to any unlicensed business entity unless a special authorization is approved by the Commissioner prior to entering into a contracted or subcontracted arrangement.

- **(j)** The Commissioner may, at his or her discretion, assess a penalty or a fine against any business entity acting as an administrator without a license for each transaction in violation of this article.

- **(k)** A licensed administrator is not permitted to market or administer any insurance product not approved in Georgia or that is issued by a nonadmitted insurer or unauthorized multiple employer self-insured health plan.

Amended by 2019 Ga. Laws 140,§ 22, eff. 7/1/2019.

Amended by 2005 Ga. Laws 108,§ 8, eff. 7/1/2005.

Section 33-23-102 - Bond and surety of applicant; liability insurance; remained licenses

- **(a)** Every applicant for an administrator's license shall file with the application and shall thereafter maintain in force a bond in favor of the Commissioner executed by a corporate surety insurer authorized to transact insurance in this state. The terms and type of the bond, including, but not limited to, total aggregate liability on the bond, shall be established by the rule or regulation of the Commissioner.
- **(b)** The bond shall remain in force until the surety is released from liability by the Commissioner or until the bond is canceled by the surety. Without prejudice to any liability accrued prior to cancellation, the surety may cancel the bond upon 30 days' advance notice, in writing, filed with the Commissioner.
- **(c)** Every applicant for an administrator's license shall obtain and shall thereafter maintain in force errors and omissions coverage or other appropriate liability insurance, written by an insurer authorized to transact insurance in this state, in an amount of at least $100,000.00.
- **(d)** The coverage required in subsection (c) of this Code section shall remain in force for a term of at least one year and shall contain language that includes that the insurer may cancel the insurance upon 60 days' advance notice filed with the Commissioner. Other terms and conditions relating to the errors and omissions policy may be imposed on the applicant as the Commissioner deems appropriate by rule or regulation.
- **(e)** In the event a licensed administrator fails to renew, surrenders, or otherwise terminates its license, it must retain both the bond and the errors and omissions coverage for a period of not less than one year after the licensee has failed to renew, surrendered, or otherwise terminated its license.

Amended by 2013 Ga. Laws 33,§ 33, eff. 4/24/2013.

Amended by 2005 Ga. Laws 108,§ 9, eff. 7/1/2005.

Section 33-23-103 - Examination of administrators by Commissioner

Administrators shall be subject to market conduct and financial examinations by the Commissioner. Any cost involved with the examinations shall be borne by the administrator.

Amended by 2005 Ga. Laws 108,§ 10, eff. 7/1/2005.

Section 33-23-104 - Establishing requirements and procedures affecting administrators

Requirements and procedures for written agreements, payments to administrators, maintenance of information, approval of advertising, underwriting provisions, premium collection, payment of claims, claim adjustment or settlement, notifications, and other matters involving administrators may be established by rule or regulation of the Commissioner.

Section 33-23-105 - Rules and regulations for implementation of article

The Commissioner may promulgate rules and regulations which are necessary to implement the provisions of this article and to ensure the safe and proper operation of administrators of this state.

Article 3 - PATIENT PROTECTION AND AFFORDABLE CARE ACT NAVIGATORS (§§ 33-23-200 — 33-23-205)

Section 33-23-200 - [See Note] Legislative findings; licensing of health insurance navigators

The General Assembly finds that the provisions of the federal Patient Protection and Affordable Care Act may cause the formation of health insurance exchanges operating in Georgia under federal law and employing navigators or navigator entities whose role will be to direct individuals and companies to health insurance policies. The General Assembly further finds that licensing and regulation of such navigators or navigator entities to ensure that they are trained and knowledgeable in the subject matter of individual and group health insurance plans and insurance coverage is necessary to avoid substantial risk to the health, safety, and welfare of the residents of this state.

Added by 2013 Ga. Laws 253,§ 1, eff. 7/1/2013, applicable only upon the notification by the federal Department of Health and Human Services or other responsible federal agency or official to the Governor, the Commissioner of Insurance, or other responsible agency or official of the State of Georgia that a health insurance exchange has been created or approved to operate within the State of Georgia pursuant to the provisions of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments thereto, or regulations or guidance issued under those acts, or upon the initiation of operation of any such exchange within the State of Georgia..

Section 33-23-201 - [See Note] Definitions

- **(1)** "Exchange" means a state, federal, or partnership exchange or marketplace operating in Georgia pursuant to Section 1311 of the federal act.
- **(2)** "Federal act" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and regulations or guidance issued under those acts.

- **(3)** "Navigator" means an individual, including assistors, application counselors, or other persons, authorized pursuant to the federal act to provide insurance advice and guidance to uninsured individuals and groups seeking health insurance coverage. For the purposes of this article, if an organization or business entity serves as a navigator, an individual performing navigator duties for that organization or business entity shall be considered to be acting in the capacity of a navigator.

- **(4)** "Patient navigator" means an individual who offers assistance to patients, families, and caregivers to help overcome health care system barriers and to facilitate timely access to quality medical and psychosocial care as defined by the health care community he or she serves.

Added by 2013 Ga. Laws 253,§ 1, eff. 7/1/2013, applicable only upon the notification by the federal Department of Health and Human Services or other responsible federal agency or official to the Governor, the Commissioner of Insurance, or other responsible agency or official of the State of Georgia that a health insurance exchange has been created or approved to operate within the State of Georgia pursuant to the provisions of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments thereto, or regulations or guidance issued under those acts, or upon the initiation of operation of any such exchange within the State of Georgia..

Section 33-23-202 - [See Note] Licensing and requirements therefor

- **(a)** No navigator shall provide advice, guidance, or other assistance with regard to health benefit plans as a navigator under the provisions of the federal act unless licensed in accordance with this article.

- **(b)** The Commissioner shall not issue a license to any applicant who does not meet or conform to the following qualifications or requirements:

  - **(1)** The applicant shall establish to the satisfaction of the Commissioner that he or she has the background, experience, knowledge, and competency in the subject matter that will enable him or her to deliver accurate information and advice to individuals and groups in this state seeking to obtain health insurance coverage under the provisions of the federal act;

  - **(2)** The applicant shall have successfully completed not less than 35 hours of instruction in health benefit insurance, the exchange provisions of the federal act, the medical assistance program provided for by Article 7 of Chapter 4 of Title 49, and the PeachCare for Kids Program provided for by Article 13 of Chapter 5 of Title 49 satisfactory to the Commissioner through a training program approved by the Commissioner;

  - **(3)** The applicant shall pass such examination as shall be required by the Commissioner unless such applicant is exempted by the Commissioner based on the applicant's experience and qualifications and pursuant to regulations adopted by the Commissioner;

  - **(4)** An applicant shall be not less than 18 years of age and of good moral character and must submit in a form approved by the Commissioner such information,

including without limitation criminal history and regulatory background information, as the Commissioner may require; and

- **(5)** An applicant for a renewal license shall have completed continuing education classes approved by the Commissioner.

Added by 2013 Ga. Laws 253,§ 1, eff. 7/1/2013, applicable only upon the notification by the federal Department of Health and Human Services or other responsible federal agency or official to the Governor, the Commissioner of Insurance, or other responsible agency or official of the State of Georgia that a health insurance exchange has been created or approved to operate within the State of Georgia pursuant to the provisions of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments thereto, or regulations or guidance issued under those acts, or upon the initiation of operation of any such exchange within the State of Georgia..

Section 33-23-203 - [See Note] Violations; limitation on solicitations; navigator compensation, responsibilities, and limitations

- **(a)** Violation of any provision of this title or the federal act, including any act or omission that would be a ground for denial, suspension, or revocation of the license of an agent as defined in Article 1 of this chapter, shall be a ground for denial, suspension, or revocation of a license under this article.

- **(b)** No navigators shall solicit any person or business that is currently insured under an existing health benefit plan.

- **(c)** No navigator shall receive any commission, compensation, or anything of value from any insurer, health benefit plan, business, or consumer for providing advice or services specifically authorized to be provided as a navigator pursuant to the provisions of the federal act. Navigators shall be compensated for advice or services rendered pursuant to the provisions of the federal act only as provided for by the federal act.

- **(d)** Navigators shall provide factually accurate information to uninsured persons and businesses regarding the availability of premium tax credits under Section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under Section 1402 of the federal act.

- **(e)** Notwithstanding any other provision of law, licensing as a navigator pursuant to the provisions of this article shall not constitute licensing as an agent or administrator as defined in Articles 1 and 2 of this chapter. No person providing advice or services as a navigator under the provisions of the federal act shall be compensated for such advice or services as the holder of a license issued pursuant to Article 1 or 2 of this chapter; provided, however, that the provisions of this subsection shall not prohibit the holder of a license issued pursuant to such articles from being compensated for advice or services rendered as such a licensee and not as a navigator. Navigators licensed pursuant to the provisions of this article shall not, except as specifically authorized by the provisions of the federal act:

- **(1)** Engage in any activities that would require licensing pursuant to the provisions of Article 1 or 2 of this chapter unless licensed thereunder;
- **(2)** Provide advice concerning the benefits, terms, and features of a particular health benefit plan or offer advice about which health benefit plan is better or worse for a particular individual or business, except in the capacity of a licensee pursuant to the provisions of Article 1 or 2 of this chapter; or
- **(3)** Recommend a particular health benefit plan or advise individuals or businesses about which health benefit plan to choose, except in the capacity of a licensee pursuant to the provisions of Article 1 or 2 of this chapter.

Added by 2013 Ga. Laws 253,§ 1, eff. 7/1/2013, applicable only upon the notification by the federal Department of Health and Human Services or other responsible federal agency or official to the Governor, the Commissioner of Insurance, or other responsible agency or official of the State of Georgia that a health insurance exchange has been created or approved to operate within the State of Georgia pursuant to the provisions of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments thereto, or regulations or guidance issued under those acts, or upon the initiation of operation of any such exchange within the State of Georgia..

Section 33-23-204 - [See Note] Adoption of rules and regulations

The Commissioner shall be authorized to adopt rules and regulations to effect the implementation of this article.

Added by 2013 Ga. Laws 253,§ 1, eff. 7/1/2013, applicable only upon the notification by the federal Department of Health and Human Services or other responsible federal agency or official to the Governor, the Commissioner of Insurance, or other responsible agency or official of the State of Georgia that a health insurance exchange has been created or approved to operate within the State of Georgia pursuant to the provisions of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments thereto, or regulations or guidance issued under those acts, or upon the initiation of operation of any such exchange within the State of Georgia..

Section 33-23-205 - [See Note] Applicability

The provisions of this article shall not apply to patient navigators as defined in paragraph (4) of Code Section 33-23-201.

Added by 2013 Ga. Laws 253,§ 1, eff. 7/1/2013, applicable only upon the notification by the federal Department of Health and Human Services or other responsible federal agency or official to the Governor, the Commissioner of Insurance, or other responsible agency or official of the State of Georgia that a health insurance exchange has been created or approved to operate within the State of Georgia pursuant to the provisions of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments thereto, or regulations or guidance issued under

those acts, or upon the initiation of operation of any such exchange within the State of Georgia..

Georgia Code § 33-6-4 and 5

2023 CODE OF GEORGIA
Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)
Chapter 6 - UNFAIR TRADE PRACTICES (§§ 33-6-1 — 33-6-37)
Article 1 - GENERAL PROVISIONS (§§ 33-6-1 — 33-6-14)
Section 33-6-4 - Enumeration of unfair methods of competition and unfair or deceptive acts or practices; penalty

Universal Citation:

GA Code § 33-6-4 (2023)

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- **(a)** As used in this Code section, the term:
  - **(1)** "Gift certificate" shall have the same meaning as provided in Code Section 10-1-393.
  - **(2)** "Policy" means any insuring bond issued by an insurer.
  - **(3)** "Store gift card" shall have the same meaning as provided in Code Section 10-1-393.
- **(b)** The following acts or practices are deemed unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:
  - **(1)** 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 his insurance business, which statement, assertion, or representation is untrue, deceptive, or misleading;
  - **(2)** 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, the benefits or advantages promised thereby, or the dividends or share of the surplus to be received thereon; making any false or misleading statement as to the dividends or share of surplus previously paid on similar policies; making any misleading representation or any misrepresentation as to the financial condition of any insurer, as to the legal reserve system upon which any life insurer operates; 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 the policyholder to lapse, forfeit, or surrender his insurance. A dividend estimate prepared on company forms and clearly indicating, in type equal in size to that used in figures showing amounts of estimated dividends, that the dividends are based on estimates made by the company based upon past experience of the company shall not be considered misrepresentation and false advertising within the meaning of this paragraph;

- **(3)** 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 substantially misrepresents the financial condition of an insurer and which is calculated to injure any person engaged in the business of insurance;
- **(4)** 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;
- **(5)** Filing with any supervisory or other public official or making, publishing, disseminating, circulating, 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 the intent to deceive;
- **(6)** 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 the insurer;
- **(7)** Issuing or delivering or permitting agents, officers, or employees to issue or deliver agency or company stock or other capital stock, benefit certificates or shares in any common-law corporation, securities, or any special or advisory board contracts of any kind promising returns and profits as an inducement to insurance;
- **(8)**
  - **(A)**
  - **(i)** Making or permitting any unfair discrimination between individuals of the same class, same policy amount, and equal expectation of life in the rates charged for any contract of life insurance or of life annuity, in the dividends or other benefits payable thereon, or in any other of the terms and conditions of the contract.
  - **(ii)** 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 sickness insurance, in the benefits payable thereunder, in any of the terms or conditions of the contract, or in any other manner whatever.

- **(iii)** Making or permitting any unfair discrimination in the issuance, renewal, or cancellation of any policy or contract of insurance against direct loss to residential property and the contents thereof, in the amount of premium, policy fees, or rates charged for the policies or contracts when the discrimination is based solely upon the age or geographical location of the property within a rated fire district without regard to objective loss experience relating thereto.

- **(iv)**

- **(I)** Unfair discrimination prohibited by the provisions of this subparagraph includes discrimination based on race, color, and national or ethnic origin. In addition, in connection with any kind of insurance, it shall be an unfair and deceptive act or practice to refuse to insure or to refuse to continue to insure an individual; to limit the amount, extent, or kind of coverage available to an individual; or to charge an individual a different rate for the same coverage because of the race, color, or national or ethnic origin of that individual. The prohibitions of this division are in addition to and supplement any and all other provisions of Georgia law prohibiting such discrimination which were previously enacted and currently exist, or which may be enacted subsequently, and shall not be a limitation on such other provisions of law.

- **(II)** A violation of this division shall give rise to a civil cause of action for damages resulting from such violation including, but not limited to, all damages recoverable for breach of insuring agreements under Georgia law including damages for bad faith and attorney's fees and costs of litigation. A violation of this division shall also give rise to the awarding of punitive or exemplary damages in an amount as may be determined by the trier of fact if such violation is found to be intentional. The remedies provided in this division are in addition to and cumulative of all other remedies that may now or hereafter be provided by law.

- **(B)** Knowingly permitting or offering to make or making any contract of insurance or agreement as to the contract other than as plainly expressed in the contract issued thereon; paying, allowing, giving, or offering to pay, allow, or give directly or indirectly, as inducement to any contract of insurance, any rebate of premiums payable on the contract, any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract, except in accordance with an applicable rate filing, rating plan, or rating system filed with and approved by the Commissioner; giving, selling, purchasing, or offering to give, sell, or purchase as inducement to such insurance or in connection therewith any stocks, bonds, or other securities of any company, any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract; or receiving or accepting as inducement to contracts of insurance any rebate of premium payable on the contract, any special favor or advantage in the dividends or other benefit to accrue thereon, or any valuable consideration or inducement not specified in the contract.

- **(C)** Nothing in subparagraphs (A) and (B) of this paragraph shall be construed as including within the definition of discrimination or rebates any of the following practices:

- **(i)** In the case of any contract of life insurance or life 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 interest of the company and its policyholders;
- **(ii)** In the case of life or accident and sickness insurance policies issued on the industrial debit or weekly premium plan, making allowance in an amount which fairly represents the saving in collection expense to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer;
- **(iii)** Making a readjustment of the rate of premium for a policy based on the loss or expense experienced at the end of the first or any subsequent policy year of insurance thereunder, which adjustment may be made retroactive only for the policy year;
- **(iv)** Issuing life or accident and sickness insurance policies covering bona fide employees of the insurer at a rate less than the rate charged other persons in the same class;
- **(v)** Issuing life or accident and sickness policies on a salary-saving, payroll deduction, preauthorized, postdated, automatic check, or draft plan at a reduced rate commensurate with the savings made by the use of such plan;
- **(vi)** Paying commissions or other compensation to duly licensed agents or brokers or allowing or returning dividends, savings, or unabsorbed premium deposits to participating policyholders, members, or subscribers;
- **(vii)** Paying by an insurance agent of part or all of the commissions on public insurance to a nonprofit association of insurance agents which is affiliated with a recognized state or national insurance agents' association, which commissions are to be used in whole or in part for one or more civic enterprises;
- **(viii)** Paying for food or refreshments by an insurer or an agent, broker, or employee of an insurer for current or prospective clients during group sales presentations and group seminars, provided that no insurance or annuity applications or contracts are offered or accepted at such presentations or seminars;
- **(ix)** Paying for business meals and entertainment by an insurer or an agent, broker, or employee of an insurer, agent, or broker for current or prospective clients; or
- **(x)** Advertising or conducting promotional programs by insurers or insurance producers whereby prizes, goods, wares, store gift cards, gift certificates, sporting event tickets, or merchandise, not exceeding $100.00 in value per customer in the aggregate in any one calendar year, are given to current or prospective customers; provided, however, that the giving of any item or items of value under this subsection shall not be contingent on the sale or renewal of a policy;

○ **(9)** Failing to instruct and require properly that agents shall, in the solicitation of insurance and the filling out of applications of insurance on behalf of

policyholders, incorporate therein all material facts relevant to the risk being written, which facts are known to the agent or could have been known by proper diligence;

- **(10)** Encouraging agents to accept applications which contain material misrepresentations or conceal material information which, if stated in the application, would prevent issuance of the policy or which would void a policy from its inception according to its terms even though premiums had been paid on the policy;

- **(11)** Any insurer or agent of same becoming a party to requiring or imposing as a condition to the sale of real or personal property or to the financing of real or personal property, as a condition to the granting of or an extension of a loan which is to be secured by the title to or a lien of any kind on real or personal property, or as a condition to the performance of any other act in connection with the sale, financing, or lending, whether the person thus acts for himself or for anyone else, that the insurance or any renewal thereof to be issued on said property as collateral to said sale or loan shall be written through any particular insurance company or agent, provided that this paragraph shall not apply to a policy purchased by the seller, financier, or lender from his or its own funds and not charged to the purchaser or borrower in the sale price of the property or the amount of the loan or required to be paid for out of his personal funds; provided, further, that such seller, financier, or lender may disapprove for reasons affecting solvency or other sensible and sufficient reasons, the insurance company selected by the buyer or borrower. This paragraph shall not apply to title insurance;

- **(12)**
  - **(A)** Representing that any insurer or agent is employed by or otherwise associated with any Medicare program as defined in Code Section 33-43-1 or the United States Social Security Administration or that any insurance policy sold or offered for sale has been endorsed or sponsored by the federal or state government.
  - **(B)** Knowingly selling or offering to sell Medicare supplement insurance coverage as defined in Code Section 33-43-1 which is not in compliance with the provisions of Chapter 43 of this title, relating to Medicare supplement insurance, or the rules and regulations promulgated by the Commissioner pursuant to Chapter 43 of this title.
  - **(C)** Representing that any individual policy is a group policy or that the insurer, agent, or policy is endorsed, sponsored by, or associated with any group, association, or other organization unless such is, in fact, the case.
  - **(D)** Knowingly selling to Medicaid recipients substantially unnecessary coverage which duplicates benefits provided under the Medicaid program without disclosing to the prospective buyer that it may not be to the buyer's benefit or that it might actually be to the buyer's detriment to purchase the additional coverage;

- **(13)**
  - **(A)** Making direct response advertising by an insurer, including radio or television advertisement, of any individual or group life insurance policy in which computation of the death benefit is of such a technical nature that such death benefit cannot reasonably be properly presented in the advertisement and understood by a member of the insuring public. Policies, other than variable life or other interest

sensitive policies, which provide for multiple changes in death benefits, combinations of increasing and nonuniformly decreasing term insurance, or increasing life insurance benefits equal to or slightly greater than the premiums paid during the early years of the coverage combined with accidental death benefits are types of contracts within the purview of this subparagraph. Additionally, any life insurance policy which cannot be truthfully, completely, clearly, and accurately disclosed in an advertisement falls within this subparagraph.

- **(B)** Making direct response advertising by an insurer, including radio or television advertisement, of any individual or group accident and sickness or life insurance policy which is misleading in fact or by implication that the coverage is "guaranteed issue" when there are conditions to be met by those persons to be insured, such as limited medical questions or other underwriting guidelines of the insurer.

- **(C)** Making direct response advertising by an insurer, including radio or television advertisement, of any individual or group accident and sickness or life insurance policy where such advertisement has not been approved for use in this state by the Commissioner;

- **(14)** Failing to disclose in printed advertising material that medical benefits are calculated on the basis of usual, customary, and reasonable charges;

- **(14.1)** Engaging in dishonest, unfair, or deceptive insurance practices in marketing or sales of insurance to service members of the armed forces of the United States and, notwithstanding any other provision of this title, the Commissioner may promulgate such rules and regulations as necessary to define dishonest, unfair, or deceptive military marketing and sales practices;

- **(14.2)** Failing to submit all claims data to the Georgia All-Payer Claims Database as required in Article 3 of Chapter 53 of Title 31;

- **(14.3)**

- **(A)** As used in this paragraph:

- **(i)** "Covered eye care services" means those health care services and materials related to the care of the eye and related structures and vision care services which a health care insurer is obligated to pay for or provide to covered persons under an eye care benefit plan, which includes services for which reimbursement is available under such plan, or for which reimbursement would be available but for the application of contractual limitations such as deductibles, copayments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation.

- **(ii)** "Covered person" means any subscriber, enrollee, member, beneficiary, or participant, or his or her dependent, for whom benefits are payable when such person receives eye care services rendered or authorized by an ophthalmologist licensed under Chapter 34 of Title 43 or an optometrist licensed under Chapter 30 of Title 43.

- **(iii)** "Eye care benefit plan" means any individual or group plan, policy contract, or subscription agreement which includes or is for eye care

services that is issued, delivered, issued for delivery, or renewed in this state whether by a health care insurer, health maintenance organization, preferred provider organization, accident and sickness insurer, fraternal benefit society, nonprofit hospital service corporation, nonprofit medical or eye care service corporation, health care plan, or any other person, firm, corporation, joint venture, or other similar business entity that pays for, purchases, or furnishes eye care services to patients, insureds, beneficiaries, or covered dependents in this state.

- **(iv)** "Health care insurer" or "insurer" means an entity, including but not limited to insurance companies, health care corporations, health maintenance organizations, and preferred provider organizations, authorized by the state to offer or provide health benefit plans, eye care benefit plans, programs, policies, subscriber contracts, or any other agreements of a similar nature which compensate or indemnify health care providers for furnishing covered eye care or other health care services.

- **(B)** No insurer shall require an ophthalmologist or optometrist to accept as payment an amount set by such insurer for services that are not covered eye care services under the covered person's eye care benefit plan as a condition to join or participate in its provider network.

- **(C)** No insurer shall draft, publish, disseminate, or circulate any explanations of benefit forms that include language that directly or indirectly states or implies that an ophthalmologist or optometrist should extend discounts to patients for noncovered eye care services.

- **(D)** No insurer shall require an ophthalmologist or optometrist within its provider network to extend any discounts on services that are not covered eye care services.

- **(E)** No insurer shall require an ophthalmologist or optometrist to extend any discounts on services that are not covered eye care services in order to receive increased payments, better reimbursements, preferential treatment, or any other benefit; or

- **(15)**

- **(A)** As used in this paragraph, the term:

- **(i)** "Confidential abuse information" means information about acts of family violence or sexual assault, the status of a victim of family violence or sexual assault, an individual's medical condition that the insurer knows or has reason to know is related to family violence or sexual assault, or the home and work addresses and telephone numbers of a subject of family violence or sexual assault.

- **(ii)** "Family violence" means family violence as defined in Code Sections 19-13-1 and 19-13-20 and as limited by Code Section 19-13-1.

- **(iii)** "Sexual assault" means rape, sodomy, aggravated sodomy, sexual battery, and aggravated sexual battery as those terms are defined in Chapter 6 of Title 16.

- **(B)** No person shall deny or refuse to accept an application; refuse to insure; refuse to renew; refuse to reissue; cancel, restrict, or otherwise terminate; charge a different rate for the same coverage; add a premium differential; or exclude or limit coverage for losses or deny a claim incurred by an insured on the basis that the applicant or insured is or has been a victim of family violence or sexual assault or that such person knows or has reason to know the applicant or insured may be a victim of family violence or sexual assault; nor shall any person take or fail to take any of the aforesaid actions on the basis that an applicant or insured provides shelter, counseling, or protection to victims of family violence or sexual assault.

- **(C)** No person shall request, directly or indirectly, any information the person knows or reasonably should know relates to acts of family violence or sexual assault or an applicant's or insured's status as a victim of family violence or sexual assault or make use of such information however obtained, except for the limited purpose of complying with legal obligations, verifying an individual's claim to be a subject of family violence or sexual assault, cooperating with a victim of family violence or sexual assault in seeking protection from family violence or sexual assault, or facilitating the treatment of a family violence or sexual assault related medical condition. When a person has information in their possession that clearly indicates that the insured or applicant is a subject of family violence or sexual assault, the disclosure or transfer of the information by a person to any person, entity, or individual is a violation of this Code section, except:

- **(i)** To the subject of family violence or sexual assault or an individual specifically designated in writing by the subject of family violence or sexual assault;

- **(ii)** To a health care provider for the direct provision of health care services;

- **(iii)** To a licensed physician identified and designated by the subject of family violence or sexual assault;

- **(iv)** When ordered by the Commissioner or a court of competent jurisdiction or otherwise required by law;

- **(v)** When necessary for a valid business purpose to transfer information that includes confidential abuse information that cannot reasonably be segregated without undue hardship. Confidential abuse information may be disclosed pursuant to this division only to the following persons or entities, all of whom shall be bound by this subparagraph:

- **(I)** A reinsurer that seeks to indemnify or indemnifies all or any part of a policy covering a subject of family violence or sexual assault and that cannot underwrite or satisfy its obligations under the reinsurance agreement without that disclosure;

- **(II)** A party to a proposed or consummated sale, transfer, merger, or consolidation of all or part of the business of the person;

- **(III)** Medical or claims personnel contracting with the person, only where necessary to process an application or perform the person's duties

under the policy or to protect the safety or privacy of a subject of family violence or sexual assault; or

- **(IV)** With respect to address and telephone number, to entities with whom the person transacts business when the business cannot be transacted without the address and telephone number;

- **(vi)** To an attorney who needs the information to represent the person effectively, provided the person notifies the attorney of its obligations under this paragraph and requests that the attorney exercise due diligence to protect the confidential abuse information consistent with the attorney's obligation to represent the person;

- **(vii)** To the policy owner or assignee, in the course of delivery of the policy, if the policy contains information about family violence or sexual assault status; or

- **(viii)** To any other entities deemed appropriate by the Commissioner.

- **(D)** It is unfairly discriminatory to terminate group coverage for a subject of family violence because coverage was originally issued in the name of the perpetrator of the family violence and the perpetrator has divorced, separated from, or lost custody of the subject of family violence, or the perpetrator's coverage has terminated voluntarily or involuntarily. If termination results from an act or omission of the perpetrator, the subject of family violence shall be deemed a qualifying eligible individual under Code Section 33-24-21.1 and may obtain continuation and conversion of such coverages notwithstanding the act or omission of the perpetrator. A person may request and receive confidential abuse information to implement the continuation and conversion of coverages under this subparagraph.

- **(E)** Subparagraph (C) of this paragraph shall not preclude a subject of family violence or sexual assault from obtaining his or her insurance records. Subparagraph (C) of this paragraph shall not prohibit a person from asking about a medical condition or a claims history or from using medical information or a claims history to underwrite or to carry out its duties under the policy to the extent otherwise permitted under this paragraph and other applicable law.

- **(F)** No person shall take action that adversely affects an applicant or insured on the basis of a medical condition, claim, or other underwriting information that the person knows or has reason to know is family violence or sexual assault related and which:

- **(i)** Has the purpose or effect of treating family violence or sexual assault status as a medical condition or underwriting criterion;

- **(ii)** Is based upon correlation between a medical condition and family violence or sexual assault;

- **(iii)** Is not otherwise permissible by law and does not apply in the same manner and to the same extent to all applicants and insureds similarly

situated without regard to whether the condition or claim is family violence or sexual assault related; or

- **(iv)** Except for claim actions, is not based on a determination, made in conformance with sound actuarial and underwriting principles and guidelines generally applied in the insurance industry and supported by reasonable statistical evidence, that there is a correlation between the applicant's or insured's circumstances and a material increase in insurance risk.

- **(G)** No person shall fail to pay losses arising out of family violence or sexual assault against an innocent first-party claimant to the extent of such claimant's legal interest in the covered property, if the loss is caused by the intentional act of an insured against whom a family violence or sexual assault complaint is brought for the act causing this loss.

- **(H)** No person shall use other exclusions or limitations on coverage which the Commissioner has determined through the policy filing and approval process to unreasonably restrict the ability of victims of family violence or sexual assault to be indemnified for such losses.

- **(I)** Any person issuing, delivering, or renewing a policy of insurance in this state at any time shall include with such policy or renewal certificate a notice attached thereto containing the following language:

"NOTICE

The laws of the State of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence."

- **(c)** Any person violating this Code section by making unlawful, false representations as to the policy sold shall be guilty of a misdemeanor.

Amended by 2023 Ga. Laws 234,§ 1, eff. 7/1/2023, app. to all policies or contracts issued, delivered, issued for delivery, or renewed in this state on or after 7/1/2023.

Amended by 2022 Ga. Laws 782,§ 33, eff. 5/2/2022.

Amended by 2021 Ga. Laws 248,§ 2, eff. 7/1/2021.

Amended by 2020 Ga. Laws 580,§ 2, eff. 8/5/2020.

Amended by 2019 Ga. Laws 273,§ 1, eff. 7/1/2019.

Amended by 2019 Ga. Laws 139,§ 1-34, eff. 7/1/2019.

Amended by 2016 Ga. Laws 444,§ 1, eff. 7/1/2016.

Amended by 2007 Ga. Laws 254,§ 1, eff. 5/24/2007.

Amended by 2006 Ga. Laws 584,§ 1, eff. 7/1/2006.

Amended by 2006 Ga. Laws 453,§ 33, eff. 4/14/2006.

Amended by 2005 Ga. Laws 108,§ 2, eff. 7/1/2005.

Amended by 2001 Ga. Laws 2, § 33, eff. 2/12/2001.

See 2021 Ga. Laws 248, § 3.

2023 CODE OF GEORGIA
Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)
Chapter 6 - UNFAIR TRADE PRACTICES (§§ 33-6-1 — 33-6-37)
Article 1 - GENERAL PROVISIONS (§§ 33-6-1 — 33-6-14)
Section 33-6-5 - Other unfair methods of competition and unfair and deceptive acts or practices

Universal Citation:

GA Code § 33-6-5 (2023)

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PreviousNext

In addition to Code Section 33-6-4, violations of the following provisions also are defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

- **(1)** No insurance company shall issue or cause to be issued any policy of insurance of any type or description upon life or property, real or personal, whenever such policy of insurance is to be furnished or delivered to the purchaser or bailee of any property, real or personal, as an inducement to purchase or bail such property, real or personal; and no other person shall advertise, offer, or give free insurance or insurance without cost or for less than the approved or customary rate in connection with the sale or bailment of real or personal property, except as provided in Chapter 27 of this title;

- **(2)** No person who is not an insurer shall assume or use any name which deceptively implies or suggests that he or she is an insurer;

- **(3)** Where the premium or charge for insurance of or involving real or personal property or merchandise is included in the overall purchase price or financing of the purchase of merchandise or property, the vendor or lender shall separately state and identify the amount charged and to be paid for the insurance and the classifications, if any, upon which based; and the inclusion or exclusion of the cost of insurance in such purchase price or financing shall not increase, reduce, or otherwise affect any other factor involved in the cost of the merchandise or property or financing as to the purchaser or borrower. A vendor or lender shall not be prohibited from charging the purchaser or borrower a finance charge otherwise permitted by law on any premium or charge for insurance included in the cost of the merchandise or property or financing. This paragraph shall not apply to credit life or credit accident and sickness insurance which is in compliance with Code Section 33-31-7;

- **(4)**
  - **(A)** No insurer shall make, offer to make, or permit any preference or distinction in property, marine, casualty, or surety insurance as to form of policy, certificate, premium, rate, or conditions of insurance based upon membership, nonmembership, or employment of any person or persons by or in any particular group, association, corporation, or organization, making the foregoing preference or distinction available in any event based upon any fictitious grouping of persons.

- **(B)** As used in this paragraph, the term "fictitious grouping" means any grouping by way of membership, nonmembership, license, franchise, employment contract, agreement, or any other method or means resulting in unfair discrimination.
- **(C)** The restrictions and limitations of this paragraph shall not extend to life or accident and sickness insurance; nor shall they apply to any bona fide association group which is composed of members engaged in a common trade, business, or profession and which has had group insurance of the same type continuously in existence for at least five years;

- **(5)** No insurer or agent thereof shall hypothecate, sell, or dispose of a promissory note received in payment of any part of a premium on a policy of insurance applied for prior to acceptance of the risk by the insurer;

- **(6)**
  - **(A)** No person shall knowingly collect any sum as premium or charge for insurance, which insurance is not then provided or not in due course to be provided subject to acceptance of the risk by the insurer by an insurance policy issued by an insurer as permitted by this title.
  - **(B)** No person shall knowingly collect as premium or charge for insurance any sum in excess of or less than the premium or charge applicable to such insurance, which sum is specified in the policy in accordance with the applicable classifications and rates as filed with and approved by the Commissioner. In cases where classifications, premiums, or rates are not required by this title to be filed and approved:
    - **(i)** The premiums and charges for insurance, except insurance written in accordance with Chapter 5 of this title, shall not be in excess of or less than those specified in the policy and as fixed by the insurer; and
    - **(ii)** The premiums and charges for insurance written in accordance with Chapter 5 of this title shall not be in excess of or less than those specified in the policy.

    This subparagraph shall not be deemed to prohibit surplus lines brokers licensed under Chapter 5 of this title from charging and collecting the amount of applicable state and federal taxes in addition to the premium required by the insurer; nor shall it be deemed to prohibit a life or accident and sickness insurer from charging and collecting amounts actually to be expended for medical examination of an applicant for life or accident and sickness insurance or for reinstatement of a life or accident and sickness insurance policy.
  - **(C)** Notwithstanding this paragraph or any other law limiting or regulating interest rates or other charges, any insurance agent or agency, as defined in Code Section 33-23-1, shall be authorized but not required to charge, receive, and collect on any unpaid premium account with a balance owing for 30 days or more a service charge which shall not exceed 15¢ per $10.00 per month computed on all amounts unpaid on the premium from month to month which need not be a calendar month or other regular period; provided, however, that, if the amount of service charge so computed shall be less than $1.00 for the month, a service charge of $1.00 for the month may be charged, received, and collected. Nothing contained in this subparagraph shall be construed to

prevent an agent, agency, or broker from canceling a policy in accordance with the laws of this state;

- **(7)**
  - **(A)** Any insurer may retain, invest in, or acquire the whole or any part of the capital stock of any other insurer or insurers or have a common management with any other insurer or insurers, unless such retention, investment, acquisition, or common management is inconsistent with any other provision of this title or unless, by reason thereof, the business of such insurers with the public is conducted in a manner which substantially lessens competition generally in the insurance business or tends to create a monopoly therein.
  - **(B)** Any person otherwise qualified may be a director of two or more insurers which are competitors, unless the effect thereof is to lessen substantially competition between insurers generally or tends materially to create a monopoly;
- **(8)** No insurance company shall cancel, modify coverage, refuse to issue, or refuse to renew any property or casualty insurance policy solely because the applicant or insured or any employee of either is mentally or physically impaired, provided that this paragraph shall not apply to accident and sickness insurance policies sold by a casualty insurer; provided, further, that this paragraph shall not be interpreted to modify any other provision of this title relating to the cancellation, modification, issuance, or renewal of any insurance policy or contract;
- **(8.1)** No insurance company shall cancel, modify coverage, refuse to issue, or refuse to renew any life insurance policy solely because the applicant or insured, acting as a living organ donor, donated all or part of a liver, pancreas, kidney, intestine, lung, or bone marrow, provided that this paragraph shall not be interpreted to modify any other provision of this title relating to the cancellation, modification, issuance, or renewal of any insurance policy or contract;
- **(9)** No insurance company, when selling salvage motor vehicles, major component parts, or parts, shall sell directly to a used motor vehicle parts dealer, motor vehicle dismantler, motor vehicle rebuilder, salvage pool dealer, or salvage dealer who is not licensed under Chapter 47 of Title 43; provided, however, this paragraph shall not prevent an insurance company from selling salvage motor vehicles, major component parts, or parts to any person, firm, or corporation when the sale is made through a used motor vehicle parts dealer, motor vehicle dismantler, motor vehicle rebuilder, salvage pool dealer, or salvage dealer who is licensed under Chapter 47 of Title 43;
- **(10)** No insurer shall refuse to insure an individual, refuse to continue to insure an individual, limit the amount, extent, or kind of coverage available to an individual, or charge an individual a different rate for coverage solely because the individual is blind or partially blind;
- **(11)** Each insurer which acquires a salvage motor vehicle, as defined in Code Section 40-3-2, shall, within 30 days of acquisition, apply for a salvage certificate of title, and no insurer shall sell, convey, or transfer any such salvage motor vehicle without first applying for and obtaining a salvage certificate of title;
- **(12)**

- **(A)** No insurer shall cancel, nonrenew, or otherwise terminate all or substantially all of an entire line or class of business for the purpose of withdrawing from the market in this state unless:
  - **(i)** The insurer has notified the Commissioner in writing of the action, including the reasons for such action, at least one year before the completion of the withdrawal, provided that this paragraph shall not be construed to prevent such insurer from canceling, nonrenewing, or terminating policies where the insurer, by contract, statute, or otherwise, has the right to do so; or
  - **(ii)** The insurer has filed a plan of action for the orderly cessation of the insurer's business within a period of time shorter than one year and such plan of action has been approved by the Commissioner.
- **(B)** At a minimum, in order to provide for orderly cessation and withdrawal, an insurer shall provide a general notice to each insured at least 90 days prior to the termination of any policy followed by a subsequent notice which meets the applicable statutory notice requirements for canceling, nonrenewing, or terminating insurance under this title.
- **(C)** An insurer's rates, rules, and forms filed pursuant to Code Sections 33-9-21 and 33-24-9 shall be considered no longer on file for use with any new business in the market affected by the insurer's withdrawal plan on and after the withdrawal plan goes into effect;

- **(12.1)** No insurer or managed care entity subject to licensing by the Commissioner shall violate any provision of Chapter 20A of this title;

- **(13)**
  - **(A)** As used in this paragraph, the term:
    - **(i)** "Aftermarket crash part" means a replacement for any of the nonmechanical sheet metal or plastic parts which generally constitute the exterior of a motor vehicle, including inner and outer panels.
    - **(ii)** "Insurer" includes an insurance company and any person authorized to represent the insurer with respect to a claim and who is acting within the scope of the person's authority.
    - **(iii)** "Nonoriginal equipment manufacturer aftermarket crash part" means an aftermarket crash part made by any manufacturer other than the original vehicle manufacturer or his or her supplier.
    - **(iv)** "Repair facility" means a motor vehicle dealer, garage, body shop, or other commercial entity which undertakes the repair or replacement of those parts that generally constitute the exterior of a motor vehicle.
  - **(B)** Any aftermarket crash part manufactured or supplied for use in this state on or after January 1, 1990, shall have affixed thereto or inscribed thereon the logo, identification number, or name of its manufacturer. Such manufacturer's logo, identification number, or name shall be visible after installation whenever practicable.

- **(C)** In all instances where nonoriginal equipment manufacturer aftermarket crash parts are used in preparing an estimate for repairs the written estimate prepared by the insurance adjuster and repair facility shall clearly identify each such part. A disclosure document attached to the estimate shall contain the following information in no smaller than ten-point type:

"THIS ESTIMATE HAS BEEN PREPARED BASED ON THE USE OF AFTERMARKET CRASH PARTS SUPPLIED BY A SOURCE OTHER THAN THE MANUFACTURER OF YOUR MOTOR VEHICLE. THE AFTERMARKET CRASH PARTS USED IN THE PREPARATION OF THIS ESTIMATE ARE WARRANTED BY THE MANUFACTURER OR DISTRIBUTOR OF SUCH PARTS RATHER THAN THE MANUFACTURER OF YOUR VEHICLE."; and

- **(14)** On and after July 1, 1992, no insurer, as defined in Code Section 33-1-2, shall issue, cause to be issued, renew, or provide coverage under any major medical insurance policy or plan containing a calendar year deductible or similar plan benefit period deductible which does not provide for a carry-over of the application of such deductible as provided in this paragraph. If all or any portion of an insured's or member's cash deductible for a calendar year or similar plan benefit period is applied against covered expenses incurred by the insured or member during the last three months of the deductible accumulation period, the insured's or member's cash deductible for the next ensuing calendar year or similar benefit plan period shall be reduced by the amount so applied. The provisions of this paragraph shall apply to major medical insurance policies or plans which have a benefit plan period of less than 24 months, except policies or plans designed and issued to be compatible with a health savings account as set out in 26 U.S.C. Section 223 or a spending account as defined in Chapter 30B of this title.

Amended by 2022 Ga. Laws 740,§ 2, eff. 7/1/2022, app. to taxable years beginning on or after 7/1/2022.

Amended by 2019 Ga. Laws 139,§ 1-35, eff. 7/1/2019.

Amended by 2005 Ga. Laws 82,§ 1, eff. 7/1/2005.

Georgia Code § 33-6-4

2023 CODE OF GEORGIA
Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)
Chapter 6 - UNFAIR TRADE PRACTICES (§§ 33-6-1 — 33-6-37)
Article 1 - GENERAL PROVISIONS (§§ 33-6-1 — 33-6-14)
Section 33-6-4 - Enumeration of unfair methods of competition and unfair or deceptive acts or practices; penalty

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PreviousNext

- **(a)** As used in this Code section, the term:
  - **(1)** "Gift certificate" shall have the same meaning as provided in Code Section 10-1-393.
  - **(2)** "Policy" means any insuring bond issued by an insurer.
  - **(3)** "Store gift card" shall have the same meaning as provided in Code Section 10-1-393.
- **(b)** The following acts or practices are deemed unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:
  - **(1)** 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 his insurance business, which statement, assertion, or representation is untrue, deceptive, or misleading;
  - **(2)** 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, the benefits or advantages promised thereby, or the dividends or share of the surplus to be received thereon; making any false or misleading statement as to the dividends or share of surplus previously paid on similar policies; making any misleading representation or any misrepresentation as to the financial condition of any insurer, as to the legal reserve system upon which any life insurer operates; 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 the policyholder to lapse, forfeit, or surrender his insurance. A dividend estimate prepared on company forms and clearly indicating, in type equal in size to that used in figures showing amounts of estimated dividends, that the dividends are based on estimates made by the company based upon past experience of the company shall not be considered misrepresentation and false advertising within the meaning of this paragraph;
  - **(3)** 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 substantially misrepresents the financial condition of an insurer and which is calculated to injure any person engaged in the business of insurance;
  - **(4)** 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;

- **(5)** Filing with any supervisory or other public official or making, publishing, disseminating, circulating, 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 the intent to deceive;
- **(6)** 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 the insurer;
- **(7)** Issuing or delivering or permitting agents, officers, or employees to issue or deliver agency or company stock or other capital stock, benefit certificates or shares in any common-law corporation, securities, or any special or advisory board contracts of any kind promising returns and profits as an inducement to insurance;
- **(8)**
  - **(A)**
  - **(i)** Making or permitting any unfair discrimination between individuals of the same class, same policy amount, and equal expectation of life in the rates charged for any contract of life insurance or of life annuity, in the dividends or other benefits payable thereon, or in any other of the terms and conditions of the contract.
  - **(ii)** 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 sickness insurance, in the benefits payable thereunder, in any of the terms or conditions of the contract, or in any other manner whatever.
  - **(iii)** Making or permitting any unfair discrimination in the issuance, renewal, or cancellation of any policy or contract of insurance against direct loss to residential property and the contents thereof, in the amount of premium, policy fees, or rates charged for the policies or contracts when the discrimination is based solely upon the age or geographical location of the property within a rated fire district without regard to objective loss experience relating thereto.
  - **(iv)**
  - **(I)** Unfair discrimination prohibited by the provisions of this subparagraph includes discrimination based on race, color, and national or ethnic origin. In addition, in connection with any kind of insurance, it shall be an unfair and deceptive act or practice to refuse to insure or to refuse to continue to insure an individual; to limit the amount, extent, or kind of coverage available to an individual; or to charge an individual a different rate for the same coverage because of the race, color, or national or ethnic origin of that individual. The prohibitions of this division are in addition to and supplement any and all other provisions of Georgia law prohibiting such

discrimination which were previously enacted and currently exist, or which may be enacted subsequently, and shall not be a limitation on such other provisions of law.

- **(II)** A violation of this division shall give rise to a civil cause of action for damages resulting from such violation including, but not limited to, all damages recoverable for breach of insuring agreements under Georgia law including damages for bad faith and attorney's fees and costs of litigation. A violation of this division shall also give rise to the awarding of punitive or exemplary damages in an amount as may be determined by the trier of fact if such violation is found to be intentional. The remedies provided in this division are in addition to and cumulative of all other remedies that may now or hereafter be provided by law.

- **(B)** Knowingly permitting or offering to make or making any contract of insurance or agreement as to the contract other than as plainly expressed in the contract issued thereon; paying, allowing, giving, or offering to pay, allow, or give directly or indirectly, as inducement to any contract of insurance, any rebate of premiums payable on the contract, any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract, except in accordance with an applicable rate filing, rating plan, or rating system filed with and approved by the Commissioner; giving, selling, purchasing, or offering to give, sell, or purchase as inducement to such insurance or in connection therewith any stocks, bonds, or other securities of any company, any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract; or receiving or accepting as inducement to contracts of insurance any rebate of premium payable on the contract, any special favor or advantage in the dividends or other benefit to accrue thereon, or any valuable consideration or inducement not specified in the contract.

- **(C)** Nothing in subparagraphs (A) and (B) of this paragraph shall be construed as including within the definition of discrimination or rebates any of the following practices:

- **(i)** In the case of any contract of life insurance or life 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 interest of the company and its policyholders;

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

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

- **(iv)** Issuing life or accident and sickness insurance policies covering bona fide employees of the insurer at a rate less than the rate charged other persons in the same class;
- **(v)** Issuing life or accident and sickness policies on a salary-saving, payroll deduction, preauthorized, postdated, automatic check, or draft plan at a reduced rate commensurate with the savings made by the use of such plan;
- **(vi)** Paying commissions or other compensation to duly licensed agents or brokers or allowing or returning dividends, savings, or unabsorbed premium deposits to participating policyholders, members, or subscribers;
- **(vii)** Paying by an insurance agent of part or all of the commissions on public insurance to a nonprofit association of insurance agents which is affiliated with a recognized state or national insurance agents' association, which commissions are to be used in whole or in part for one or more civic enterprises;
- **(viii)** Paying for food or refreshments by an insurer or an agent, broker, or employee of an insurer for current or prospective clients during group sales presentations and group seminars, provided that no insurance or annuity applications or contracts are offered or accepted at such presentations or seminars;
- **(ix)** Paying for business meals and entertainment by an insurer or an agent, broker, or employee of an insurer, agent, or broker for current or prospective clients; or
- **(x)** Advertising or conducting promotional programs by insurers or insurance producers whereby prizes, goods, wares, store gift cards, gift certificates, sporting event tickets, or merchandise, not exceeding $100.00 in value per customer in the aggregate in any one calendar year, are given to current or prospective customers; provided, however, that the giving of any item or items of value under this subsection shall not be contingent on the sale or renewal of a policy;

○ **(9)** Failing to instruct and require properly that agents shall, in the solicitation of insurance and the filling out of applications of insurance on behalf of policyholders, incorporate therein all material facts relevant to the risk being written, which facts are known to the agent or could have been known by proper diligence;

○ **(10)** Encouraging agents to accept applications which contain material misrepresentations or conceal material information which, if stated in the application, would prevent issuance of the policy or which would void a policy from its inception according to its terms even though premiums had been paid on the policy;

○ **(11)** Any insurer or agent of same becoming a party to requiring or imposing as a condition to the sale of real or personal property or to the financing of real or personal property, as a condition to the granting of or an extension of a loan which is to be secured by the title to or a lien of any kind on real or personal property, or as a condition to the performance of any other act in connection with the sale, financing, or lending, whether the person thus acts for himself or for anyone else, that the insurance or any renewal thereof to be issued on said property as collateral to said sale or loan shall be written through any particular insurance company or agent, provided that this paragraph shall not apply to a policy purchased by the seller, financier, or lender from

his or its own funds and not charged to the purchaser or borrower in the sale price of the property or the amount of the loan or required to be paid for out of his personal funds; provided, further, that such seller, financier, or lender may disapprove for reasons affecting solvency or other sensible and sufficient reasons, the insurance company selected by the buyer or borrower. This paragraph shall not apply to title insurance;

- **(12)**
  - **(A)** Representing that any insurer or agent is employed by or otherwise associated with any Medicare program as defined in Code Section 33-43-1 or the United States Social Security Administration or that any insurance policy sold or offered for sale has been endorsed or sponsored by the federal or state government.
  - **(B)** Knowingly selling or offering to sell Medicare supplement insurance coverage as defined in Code Section 33-43-1 which is not in compliance with the provisions of Chapter 43 of this title, relating to Medicare supplement insurance, or the rules and regulations promulgated by the Commissioner pursuant to Chapter 43 of this title.
  - **(C)** Representing that any individual policy is a group policy or that the insurer, agent, or policy is endorsed, sponsored by, or associated with any group, association, or other organization unless such is, in fact, the case.
  - **(D)** Knowingly selling to Medicaid recipients substantially unnecessary coverage which duplicates benefits provided under the Medicaid program without disclosing to the prospective buyer that it may not be to the buyer's benefit or that it might actually be to the buyer's detriment to purchase the additional coverage;
- **(13)**
  - **(A)** Making direct response advertising by an insurer, including radio or television advertisement, of any individual or group life insurance policy in which computation of the death benefit is of such a technical nature that such death benefit cannot reasonably be properly presented in the advertisement and understood by a member of the insuring public. Policies, other than variable life or other interest sensitive policies, which provide for multiple changes in death benefits, combinations of increasing and nonuniformly decreasing term insurance, or increasing life insurance benefits equal to or slightly greater than the premiums paid during the early years of the coverage combined with accidental death benefits are types of contracts within the purview of this subparagraph. Additionally, any life insurance policy which cannot be truthfully, completely, clearly, and accurately disclosed in an advertisement falls within this subparagraph.
  - **(B)** Making direct response advertising by an insurer, including radio or television advertisement, of any individual or group accident and sickness or life insurance policy which is misleading in fact or by implication that the coverage is "guaranteed issue" when there are conditions to be met by those persons to be insured, such as limited medical questions or other underwriting guidelines of the insurer.
  - **(C)** Making direct response advertising by an insurer, including radio or television advertisement, of any individual or group accident and sickness or life

insurance policy where such advertisement has not been approved for use in this state by the Commissioner;

- **(14)** Failing to disclose in printed advertising material that medical benefits are calculated on the basis of usual, customary, and reasonable charges;

- **(14.1)** Engaging in dishonest, unfair, or deceptive insurance practices in marketing or sales of insurance to service members of the armed forces of the United States and, notwithstanding any other provision of this title, the Commissioner may promulgate such rules and regulations as necessary to define dishonest, unfair, or deceptive military marketing and sales practices;

- **(14.2)** Failing to submit all claims data to the Georgia All-Payer Claims Database as required in Article 3 of Chapter 53 of Title 31;

- **(14.3)**

  - **(A)** As used in this paragraph:

  - **(i)** "Covered eye care services" means those health care services and materials related to the care of the eye and related structures and vision care services which a health care insurer is obligated to pay for or provide to covered persons under an eye care benefit plan, which includes services for which reimbursement is available under such plan, or for which reimbursement would be available but for the application of contractual limitations such as deductibles, copayments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation.

  - **(ii)** "Covered person" means any subscriber, enrollee, member, beneficiary, or participant, or his or her dependent, for whom benefits are payable when such person receives eye care services rendered or authorized by an ophthalmologist licensed under Chapter 34 of Title 43 or an optometrist licensed under Chapter 30 of Title 43.

  - **(iii)** "Eye care benefit plan" means any individual or group plan, policy contract, or subscription agreement which includes or is for eye care services that is issued, delivered, issued for delivery, or renewed in this state whether by a health care insurer, health maintenance organization, preferred provider organization, accident and sickness insurer, fraternal benefit society, nonprofit hospital service corporation, nonprofit medical or eye care service corporation, health care plan, or any other person, firm, corporation, joint venture, or other similar business entity that pays for, purchases, or furnishes eye care services to patients, insureds, beneficiaries, or covered dependents in this state.

  - **(iv)** "Health care insurer" or "insurer" means an entity, including but not limited to insurance companies, health care corporations, health maintenance organizations, and preferred provider organizations, authorized by the state to offer or provide health benefit plans, eye care benefit plans, programs, policies, subscriber contracts, or any other agreements of a similar nature which compensate or indemnify health care providers for furnishing covered eye care or other health care services.

- **(B)** No insurer shall require an ophthalmologist or optometrist to accept as payment an amount set by such insurer for services that are not covered eye care services under the covered person's eye care benefit plan as a condition to join or participate in its provider network.
- **(C)** No insurer shall draft, publish, disseminate, or circulate any explanations of benefit forms that include language that directly or indirectly states or implies that an ophthalmologist or optometrist should extend discounts to patients for noncovered eye care services.
- **(D)** No insurer shall require an ophthalmologist or optometrist within its provider network to extend any discounts on services that are not covered eye care services.
- **(E)** No insurer shall require an ophthalmologist or optometrist to extend any discounts on services that are not covered eye care services in order to receive increased payments, better reimbursements, preferential treatment, or any other benefit; or

○ **(15)**

- **(A)** As used in this paragraph, the term:
- **(i)** "Confidential abuse information" means information about acts of family violence or sexual assault, the status of a victim of family violence or sexual assault, an individual's medical condition that the insurer knows or has reason to know is related to family violence or sexual assault, or the home and work addresses and telephone numbers of a subject of family violence or sexual assault.
- **(ii)** "Family violence" means family violence as defined in Code Sections 19-13-1 and 19-13-20 and as limited by Code Section 19-13-1.
- **(iii)** "Sexual assault" means rape, sodomy, aggravated sodomy, sexual battery, and aggravated sexual battery as those terms are defined in Chapter 6 of Title 16.
- **(B)** No person shall deny or refuse to accept an application; refuse to insure; refuse to renew; refuse to reissue; cancel, restrict, or otherwise terminate; charge a different rate for the same coverage; add a premium differential; or exclude or limit coverage for losses or deny a claim incurred by an insured on the basis that the applicant or insured is or has been a victim of family violence or sexual assault or that such person knows or has reason to know the applicant or insured may be a victim of family violence or sexual assault; nor shall any person take or fail to take any of the aforesaid actions on the basis that an applicant or insured provides shelter, counseling, or protection to victims of family violence or sexual assault.
- **(C)** No person shall request, directly or indirectly, any information the person knows or reasonably should know relates to acts of family violence or sexual assault or an applicant's or insured's status as a victim of family violence or sexual assault or make use of such information however obtained, except for the limited purpose of complying with legal obligations, verifying an individual's claim to be a subject of family violence or sexual assault, cooperating with a victim of family violence

or sexual assault in seeking protection from family violence or sexual assault, or facilitating the treatment of a family violence or sexual assault related medical condition. When a person has information in their possession that clearly indicates that the insured or applicant is a subject of family violence or sexual assault, the disclosure or transfer of the information by a person to any person, entity, or individual is a violation of this Code section, except:

- **(i)** To the subject of family violence or sexual assault or an individual specifically designated in writing by the subject of family violence or sexual assault;
- **(ii)** To a health care provider for the direct provision of health care services;
- **(iii)** To a licensed physician identified and designated by the subject of family violence or sexual assault;
- **(iv)** When ordered by the Commissioner or a court of competent jurisdiction or otherwise required by law;
- **(v)** When necessary for a valid business purpose to transfer information that includes confidential abuse information that cannot reasonably be segregated without undue hardship. Confidential abuse information may be disclosed pursuant to this division only to the following persons or entities, all of whom shall be bound by this subparagraph:
- **(I)** A reinsurer that seeks to indemnify or indemnifies all or any part of a policy covering a subject of family violence or sexual assault and that cannot underwrite or satisfy its obligations under the reinsurance agreement without that disclosure;
- **(II)** A party to a proposed or consummated sale, transfer, merger, or consolidation of all or part of the business of the person;
- **(III)** Medical or claims personnel contracting with the person, only where necessary to process an application or perform the person's duties under the policy or to protect the safety or privacy of a subject of family violence or sexual assault; or
- **(IV)** With respect to address and telephone number, to entities with whom the person transacts business when the business cannot be transacted without the address and telephone number;
- **(vi)** To an attorney who needs the information to represent the person effectively, provided the person notifies the attorney of its obligations under this paragraph and requests that the attorney exercise due diligence to protect the confidential abuse information consistent with the attorney's obligation to represent the person;
- **(vii)** To the policy owner or assignee, in the course of delivery of the policy, if the policy contains information about family violence or sexual assault status; or

- **(viii)** To any other entities deemed appropriate by the Commissioner.

- **(D)** It is unfairly discriminatory to terminate group coverage for a subject of family violence because coverage was originally issued in the name of the perpetrator of the family violence and the perpetrator has divorced, separated from, or lost custody of the subject of family violence, or the perpetrator's coverage has terminated voluntarily or involuntarily. If termination results from an act or omission of the perpetrator, the subject of family violence shall be deemed a qualifying eligible individual under Code Section 33-24-21.1 and may obtain continuation and conversion of such coverages notwithstanding the act or omission of the perpetrator. A person may request and receive confidential abuse information to implement the continuation and conversion of coverages under this subparagraph.

- **(E)** Subparagraph (C) of this paragraph shall not preclude a subject of family violence or sexual assault from obtaining his or her insurance records. Subparagraph (C) of this paragraph shall not prohibit a person from asking about a medical condition or a claims history or from using medical information or a claims history to underwrite or to carry out its duties under the policy to the extent otherwise permitted under this paragraph and other applicable law.

- **(F)** No person shall take action that adversely affects an applicant or insured on the basis of a medical condition, claim, or other underwriting information that the person knows or has reason to know is family violence or sexual assault related and which:

- **(i)** Has the purpose or effect of treating family violence or sexual assault status as a medical condition or underwriting criterion;

- **(ii)** Is based upon correlation between a medical condition and family violence or sexual assault;

- **(iii)** Is not otherwise permissible by law and does not apply in the same manner and to the same extent to all applicants and insureds similarly situated without regard to whether the condition or claim is family violence or sexual assault related; or

- **(iv)** Except for claim actions, is not based on a determination, made in conformance with sound actuarial and underwriting principles and guidelines generally applied in the insurance industry and supported by reasonable statistical evidence, that there is a correlation between the applicant's or insured's circumstances and a material increase in insurance risk.

- **(G)** No person shall fail to pay losses arising out of family violence or sexual assault against an innocent first-party claimant to the extent of such claimant's legal interest in the covered property, if the loss is caused by the intentional act of an insured against whom a family violence or sexual assault complaint is brought for the act causing this loss.

- **(H)** No person shall use other exclusions or limitations on coverage which the Commissioner has determined through the policy filing and approval process

to unreasonably restrict the ability of victims of family violence or sexual assault to be indemnified for such losses.

- **(l)** Any person issuing, delivering, or renewing a policy of insurance in this state at any time shall include with such policy or renewal certificate a notice attached thereto containing the following language:

"NOTICE

The laws of the State of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence."

- **(c)** Any person violating this Code section by making unlawful, false representations as to the policy sold shall be guilty of a misdemeanor.

Amended by 2023 Ga. Laws 234,§ 1, eff. 7/1/2023, app. to all policies or contracts issued, delivered, issued for delivery, or renewed in this state on or after 7/1/2023.

Amended by 2022 Ga. Laws 782,§ 33, eff. 5/2/2022.

Amended by 2021 Ga. Laws 248,§ 2, eff. 7/1/2021.

Amended by 2020 Ga. Laws 580,§ 2, eff. 8/5/2020.

Amended by 2019 Ga. Laws 273,§ 1, eff. 7/1/2019.

Amended by 2019 Ga. Laws 139,§ 1-34, eff. 7/1/2019.

Amended by 2016 Ga. Laws 444,§ 1, eff. 7/1/2016.

Amended by 2007 Ga. Laws 254,§ 1, eff. 5/24/2007.

Amended by 2006 Ga. Laws 584,§ 1, eff. 7/1/2006.

Amended by 2006 Ga. Laws 453,§ 33, eff. 4/14/2006.

Amended by 2005 Ga. Laws 108,§ 2, eff. 7/1/2005.

Amended by 2001 Ga. Laws 2, § 33, eff. 2/12/2001.

See 2021 Ga. Laws 248, § 3.

Georgia Code § 33-6-34

2023 CODE OF GEORGIA
Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)
Chapter 6 - UNFAIR TRADE PRACTICES (§§ 33-6-1 — 33-6-37)
Article 2 - UNFAIR CLAIMS SETTLEMENT PRACTICES (§§ 33-6-30 — 33-6-37)
Section 33-6-34 - Unfair claims settlement practices

Universal Citation:

GA Code § 33-6-34 (2023)

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Any of the following acts of an insurer when committed as provided in Code Section 33-6-33 shall constitute an unfair claims settlement practice:

- **(1)** Knowingly misrepresenting to claimants and insureds relevant facts or policy provisions relating to coverages at issue;
- **(2)** Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies;
- **(3)** Failing to adopt and implement procedures for the prompt investigation and settlement of claims arising under its policies;
- **(4)** Not attempting in good faith to effectuate prompt, fair, and equitable settlement of claims submitted in which liability has become reasonably clear;
- **(5)** Compelling insureds or beneficiaries to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them;
- **(6)** Refusing to pay claims without conducting a reasonable investigation;
- **(7)** When requested by the insured in writing, failing to affirm or deny coverage of claims within a reasonable time after having completed its investigation related to such claim or claims;
- **(8)** When requested by the insured in writing, making claims payments to an insured or beneficiary without indicating the coverage under which each payment is being made;
- **(9)** Unreasonably delaying the investigation or payment of claims by requiring both a formal proof of loss and subsequent verification that would result in duplication of information and verification appearing in the formal proof of loss form; provided, however, this paragraph shall not preclude an insurer from obtaining sworn statements if permitted under the policy;
- **(10)** When requested by the insured in writing, failing in the case of claims denial or offers of compromise settlement to provide promptly a reasonable and accurate explanation of the basis for such actions. In the case of claims denials, such denials shall be in writing;
- **(11)** Failing to provide forms necessary to file claims within 15 calendar days of a request with reasonable explanations regarding their use;
- **(12)** Failing to adopt and implement reasonable standards to assure that the repairs of a repairer owned by the insurer are performed in a workmanlike manner;
- **(13)** Indicating to a first-party claimant on a payment, draft check, or accompanying letter that said payment is final or a release of any claim unless the policy limit has been paid or there has been a compromise settlement agreed to by the first-party claimant and the insurer as to coverage and amount payable under the contract;

- **(14)** Issuing checks or drafts in partial settlement of a loss or claim under a specific coverage which contain language which releases the insurer or its insured from its total liability;
- **(15)** Failure to comply with any insurer requirement in Chapter 20E of this title, the "Surprise Billing Consumer Protection Act," including:
  - **(A)** The failure to designate whether the healthcare plan is subject to the exclusive jurisdiction of the Employee Retirement Income Security Act of 1974, 29 U.S.C. Sec. 1001, et seq.;
  - **(B)** The failure to directly pay the provider or facility within 15 working days for electronic claims or 30 calendar days for paper claims any moneys due under Code Section 33-20E-4 or 33-20E-5; or
  - **(C)** The failure to pay a resolution organization as required under Code Section 33-20E-16; and
- **(16)** Failure to comply with any insurer requirement relating to emergency services or care in Article 4 of Chapter 11 of Title 31, Article 1 of Chapter 20A of this title, Chapter 20E of this title, Chapter 21A of this title, Code Section 33-24-59.27, and Chapter 30 of this title.

Amended by 2023 Ga. Laws 223,§ 1, eff. 7/1/2023.

Amended by 2022 Ga. Laws 833,§ 3, eff. 7/1/2022.

Amended by 2020 Ga. Laws 470,§ 2, eff. 1/1/2021.

Georgia Code § 33-6-35

2023 CODE OF GEORGIA
Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)
Chapter 6 - UNFAIR TRADE PRACTICES (§§ 33-6-1 — 33-6-37)
Article 2 - UNFAIR CLAIMS SETTLEMENT PRACTICES (§§ 33-6-30 — 33-6-37)
Section 33-6-35 - Notice of hearing; hearing procedures; cease and desist orders; penalties; judicial review; intervenors

- **(a)** Whenever the Commissioner has reason to believe that any person has engaged or is engaging in this state in any unfair claims settlement practice and has reason to believe that a proceeding with respect to such unfair claims settlement practice would be in the public interest, the Commissioner shall serve upon such person a statement of the charges in that respect and a notice of hearing in the same manner as provided in Code Section 33-6-7.
- **(b)** The provisions of Code Sections 33-6-7 through 33-6-11, relating to hearings, cease and desist orders, penalties, judicial review, intervenors, and other matters in connection with violations of Article 1 of this chapter shall be applicable to violations of this article.

Georgia Code § 33-9-36

2023 CODE OF GEORGIA
Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)
Chapter 6 - UNFAIR TRADE PRACTICES (§§ 33-6-1 — 33-6-37)
Article 2 - UNFAIR CLAIMS SETTLEMENT PRACTICES (§§ 33-6-30 — 33-6-37)
Section 33-6-36 - Rules and regulations

The Commissioner may, in accordance with the procedures set forth in Code Section 33-2-9, promulgate rules and regulations necessary to implement and enforce the provisions of this article. If the Commissioner should find that extraordinary circumstances exist and that it would be in the best interests of the citizens of this state, the Commissioner may suspend temporarily the applicability of any rule or regulation promulgated pursuant to this article.

Georgia Code § 33-23-1

2023 CODE OF GEORGIA
Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)
Chapter 23 - LICENSING OF AGENTS, AGENCIES, SUBAGENTS, COUNSELORS, AND ADJUSTERS (§§ 33-23-1 — 33-23-205)
Article 1 - AGENTS, AGENCIES, SUBAGENTS, COUNSELORS, AND ADJUSTERS (§§ 33-23-1 — 33-23-46)
Section 33-23-1 - Definitions

Universal Citation:

GA Code § 33-23-1 (2023)

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- **(a)** As used in this article, the term:
  - **(1)** "Adjuster" means any individual who for a fee, commission, salary, or other compensation investigates, settles, or adjusts and reports to his or her employer or principal with respect to claims arising under insurance contracts on behalf of the insurer or the insured or a person who directly supervises or manages such individual. The term "adjuster" does not include:
    - **(A)** Individuals who adjust claims arising under contracts of life or marine insurance or annuities; or
    - **(B)** An agent or a salaried employee of an agent or a salaried employee of an insurer who adjusts or assists in adjusting losses under policies issued by such agent or insurer.
  - **(2)** "Agency" means a business entity which represents one or more insurers and is engaged in the business of selling, soliciting, or negotiating insurance. Agency also means a business entity insurance producer.

- **(3)** "Agent" means an individual appointed or employed by an insurer who sells, solicits, or negotiates insurance. Agent also means an individual insurance producer.
- **(3.1)** "Automated claims adjudication system" means a preprogrammed computer system designed for the collection, data entry, calculation, and final resolution of property insurance claims used only for portable electronics as defined in paragraph (1) of subsection (d) of Code Section 33-23-12 which:
  - **(A)** May only be utilized by a licensed independent adjuster, licensed agent, or supervised individuals operating pursuant to this paragraph;
  - **(B)** Shall comply with all claims payment requirements of the Georgia Insurance Code; and
  - **(C)** Shall be certified as compliant with this Code section by a licensed independent adjuster that is an officer of a business entity licensed under this chapter.
- **(4)** "Business entity" means a corporation, association, partnership, sole proprietorship, limited liability company, limited liability partnership, or other legal entity.
- **(5)** "Controlled business of a person" means property or casualty insurance for a person or a person's spouse; for any relative by blood or marriage within the second degree of kinship as defined by paragraph (5) of Code Section 53-4-2; for a person's employer or the firm of which a person is a member; for any officer, director, stockholder, or member of a person's employer or of any firm of which a person is a partner; for any spouse of the officer, director, employer, stockholder, or member of a person's firm; for a person's ward or employee; or for any person or in regard to any property under a person's control or supervision in any fiduciary capacity.
- **(6)** "Counselor" means any individual who engages or advertises or holds himself or herself out as engaging in the business of counseling, advising, or rendering opinions as to the benefits promised under any contract of insurance issued or offered by any insurer or as to the terms, value, effect, advantages, or disadvantages under the contract of insurance, other than an actuary or consultant advising insurers. When receiving a fee, commission, or other compensation for this service, such individual shall not receive any compensation from any other source on or relating to the same transaction.
- **(7)** "Home state" means Canada, the District of Columbia, and any state or territory of the United States in which an insurance producer or adjuster maintains his or her principal place of residence or principal place of business and is licensed to act as an insurance producer or adjuster.
- **(8)** "Independent adjuster" means an adjuster representing the interest of the insurer who is not an employee of such insurer.
- **(9)** "Insurance," except where the type of insurance is specifically stated, means all kinds of insurance other than bail bonding by individual sureties.
- **(10)** "Insurance producer" means a person required to be licensed under the laws of this state to sell, solicit, or negotiate insurance.

- **(10.1)** "Limited subagent" means an individual licensed on behalf of a licensed agent pursuant to Code Section 33-23-12.
- **(11)** "Negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms, or conditions of the contract, provided that the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers.
- **(12)** "Person" means an individual or business entity.
- **(13)** "Public adjuster" means any person who solicits, advertises for, or otherwise agrees to represent only a person who is insured under a policy covering fire, windstorm, water damage, and other physical damage to real and personal property other than vehicles licensed for the road, and any such representation shall be limited to the settlement of a claim or claims under the policy for damages to real and personal property, including related loss of income and living expense losses but excluding claims arising out of any motor vehicle accident, and who, for compensation on behalf of an insured:
  - **(A)** Acts or aids, solely in relation to first-party claims arising under insurance contracts that insure the real or personal property of the insured, in negotiating for, or effecting the settlement of, a claim for loss or damage covered by an insurance contract;
  - **(B)** Advertises for employment as a public adjuster of insurance claims or solicits business or represents himself or herself to the public as a public adjuster of first-party claims for losses or damages arising out of policies of insurance that insure real or personal property; or
  - **(C)** Directly or indirectly solicits business, investigates or adjusts losses, or advises an insured about first-party claims for losses or damages arising out of policies of insurance that insure real or personal property for another person engaged in the business of adjusting losses or damages covered by an insurance policy.
- **(14)** "Sell" means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurance company.
- **(15)** "Solicit" means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular company.
- **(16)** "Subagent" means any licensed agent, except as provided in Code Section 33-23-12, who acts for or on behalf of another licensed agent in the selling of, solicitation of, or negotiation for an insurance contract or annuity contract and who has on file with the Commissioner a certificate of authority from each agent with whom the subagent places insurance. Subagent also means subproducer. The term "subagent" shall not include:
  - **(A)** An agent who places insurance with or through another agent involving 12 or fewer policies or certificates of insurance in any one calendar year; or
  - **(B)** An agent who places surplus lines insurance with or through a surplus lines broker only with respect to such surplus lines insurance.

- **(17)** "Surplus lines broker" means an individual licensed pursuant to Code Section 33-23-37.

- **(b)** The definitions of agent, subagent, and counselor in subsection (a) of this Code section shall not be deemed to include:

- **(1)** An attorney at law admitted to practice in this state, when handling the collections of premiums or advising clients as to insurance as a function incidental to the practice of law or who adjusts losses which are incidental to the practice of his or her profession;

- **(2)** Any representative of ocean marine insurers;

- **(3)** Any representative of farmers' mutual fire insurance companies as defined in Chapter 16 of this title;

- **(4)** A salaried employee of a credit or character reporting firm or agency not engaged in the insurance business who may, however, report to an insurer;

- **(5)** A person acting for or as a collection agency;

- **(6)** A person who makes the salary deductions of premiums for employees or, under a group insurance plan, a person who serves the master policyholder of group insurance in administering the details of such insurance for the employees or debtors of the master policyholder or of a firm or corporation by which the person is employed and who does not receive insurance commissions for such service; provided, further, that an administration fee not exceeding 5 percent of the premiums collected paid by the insurer to the administration office shall not be construed to be an insurance commission;

- **(7)** Persons exempted from licensure as provided in subsection (h) of Code Section 33-23-4; or

- **(8)** An individual who collects claim information from, or furnishes claim information to, insureds or claimants, who conducts data entry, and who enters data into an automated claims adjudication system, provided that the individual is an employee of a licensed independent adjuster or its affiliate where no more than 25 such persons are under the supervision of one licensed independent adjustor or licensed agent.

- **(c)** In addition to paragraphs (2) through (8) of subsection (b) of this Code section, the definitions of public adjuster, independent adjuster, and adjuster in subsection (a) of this Code section shall not be deemed to include an attorney admitted to practice law in this state.

Amended by 2014 Ga. Laws 504,§ 1 and § 2, eff. 7/1/2014.

Amended by 2012 Ga. Laws 776,§ 5, eff. 7/1/2012.

Amended by 2012 Ga. Laws 776,§ 4, eff. 7/1/2012.

Amended by 2012 Ga. Laws 776,§ 3, eff. 7/1/2012.

Amended by 2012 Ga. Laws 727,§ 6, eff. 7/1/2012.

Amended by 2012 Ga. Laws 727,§ 5, eff. 7/1/2012.

Amended by 2012 Ga. Laws 727,§ 4, eff. 7/1/2012.

Amended by 2008 Ga. Laws 767,§ 1, eff. 7/1/2008.

Amended by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Georgia Code § 33-6-34

2023 CODE OF GEORGIA
Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)
Chapter 6 - UNFAIR TRADE PRACTICES (§§ 33-6-1 — 33-6-37)
Article 2 - UNFAIR CLAIMS SETTLEMENT PRACTICES (§§ 33-6-30 — 33-6-37)
Section 33-6-34 - Unfair claims settlement practices

Universal Citation:

GA Code § 33-6-34 (2023)

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PreviousNext

Any of the following acts of an insurer when committed as provided in Code Section 33-6-33 shall constitute an unfair claims settlement practice:

- **(1)** Knowingly misrepresenting to claimants and insureds relevant facts or policy provisions relating to coverages at issue;
- **(2)** Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies;
- **(3)** Failing to adopt and implement procedures for the prompt investigation and settlement of claims arising under its policies;
- **(4)** Not attempting in good faith to effectuate prompt, fair, and equitable settlement of claims submitted in which liability has become reasonably clear;
- **(5)** Compelling insureds or beneficiaries to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them;
- **(6)** Refusing to pay claims without conducting a reasonable investigation;
- **(7)** When requested by the insured in writing, failing to affirm or deny coverage of claims within a reasonable time after having completed its investigation related to such claim or claims;
- **(8)** When requested by the insured in writing, making claims payments to an insured or beneficiary without indicating the coverage under which each payment is being made;
- **(9)** Unreasonably delaying the investigation or payment of claims by requiring both a formal proof of loss and subsequent verification that would result in duplication of information and verification appearing in the formal proof of loss form; provided,

however, this paragraph shall not preclude an insurer from obtaining sworn statements if permitted under the policy;

- **(10)** When requested by the insured in writing, failing in the case of claims denial or offers of compromise settlement to provide promptly a reasonable and accurate explanation of the basis for such actions. In the case of claims denials, such denials shall be in writing;
- **(11)** Failing to provide forms necessary to file claims within 15 calendar days of a request with reasonable explanations regarding their use;
- **(12)** Failing to adopt and implement reasonable standards to assure that the repairs of a repairer owned by the insurer are performed in a workmanlike manner;
- **(13)** Indicating to a first-party claimant on a payment, draft check, or accompanying letter that said payment is final or a release of any claim unless the policy limit has been paid or there has been a compromise settlement agreed to by the first-party claimant and the insurer as to coverage and amount payable under the contract;
- **(14)** Issuing checks or drafts in partial settlement of a loss or claim under a specific coverage which contain language which releases the insurer or its insured from its total liability;
- **(15)** Failure to comply with any insurer requirement in Chapter 20E of this title, the "Surprise Billing Consumer Protection Act," including:
  - **(A)** The failure to designate whether the healthcare plan is subject to the exclusive jurisdiction of the Employee Retirement Income Security Act of 1974, 29 U.S.C. Sec. 1001, et seq.;
  - **(B)** The failure to directly pay the provider or facility within 15 working days for electronic claims or 30 calendar days for paper claims any moneys due under Code Section 33-20E-4 or 33-20E-5; or
  - **(C)** The failure to pay a resolution organization as required under Code Section 33-20E-16; and
- **(16)** Failure to comply with any insurer requirement relating to emergency services or care in Article 4 of Chapter 11 of Title 31, Article 1 of Chapter 20A of this title, Chapter 20E of this title, Chapter 21A of this title, Code Section 33-24-59.27, and Chapter 30 of this title.

Amended by 2023 Ga. Laws 223,§ 1, eff. 7/1/2023.

Amended by 2022 Ga. Laws 833,§ 3, eff. 7/1/2022.

Amended by 2020 Ga. Laws 470,§ 2, eff. 1/1/2021.

Georgia Code § 33-6-4

2023 CODE OF GEORGIA
Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)
Chapter 6 - UNFAIR TRADE PRACTICES (§§ 33-6-1 — 33-6-37)

Article 1 - GENERAL PROVISIONS (§§ 33-6-1 — 33-6-14)
Section 33-6-4 - Enumeration of unfair methods of competition and unfair or deceptive acts or practices; penalty

Universal Citation:

GA Code § 33-6-4 (2023)

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PreviousNext

- **(a)** As used in this Code section, the term:
  - **(1)** "Gift certificate" shall have the same meaning as provided in Code Section 10-1-393.
  - **(2)** "Policy" means any insuring bond issued by an insurer.
  - **(3)** "Store gift card" shall have the same meaning as provided in Code Section 10-1-393.
- **(b)** The following acts or practices are deemed unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:
  - **(1)** 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 his insurance business, which statement, assertion, or representation is untrue, deceptive, or misleading;
  - **(2)** 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, the benefits or advantages promised thereby, or the dividends or share of the surplus to be received thereon; making any false or misleading statement as to the dividends or share of surplus previously paid on similar policies; making any misleading representation or any misrepresentation as to the financial condition of any insurer, as to the legal reserve system upon which any life insurer operates; 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 the policyholder to lapse, forfeit, or surrender his insurance. A dividend estimate prepared on company forms and clearly indicating, in type equal in size to that used in figures showing amounts of estimated dividends, that the dividends are based on estimates made by the company based upon past experience of the company shall not be considered misrepresentation and false advertising within the meaning of this paragraph;
  - **(3)** 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 substantially misrepresents the financial condition of an insurer and which is calculated to injure any person engaged in the business of insurance;

- **(4)** 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;
- **(5)** Filing with any supervisory or other public official or making, publishing, disseminating, circulating, 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 the intent to deceive;
- **(6)** 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 the insurer;
- **(7)** Issuing or delivering or permitting agents, officers, or employees to issue or deliver agency or company stock or other capital stock, benefit certificates or shares in any common-law corporation, securities, or any special or advisory board contracts of any kind promising returns and profits as an inducement to insurance;
- **(8)**
  - **(A)**
  - **(i)** Making or permitting any unfair discrimination between individuals of the same class, same policy amount, and equal expectation of life in the rates charged for any contract of life insurance or of life annuity, in the dividends or other benefits payable thereon, or in any other of the terms and conditions of the contract.
  - **(ii)** 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 sickness insurance, in the benefits payable thereunder, in any of the terms or conditions of the contract, or in any other manner whatever.
  - **(iii)** Making or permitting any unfair discrimination in the issuance, renewal, or cancellation of any policy or contract of insurance against direct loss to residential property and the contents thereof, in the amount of premium, policy fees, or rates charged for the policies or contracts when the discrimination is based solely upon the age or geographical location of the property within a rated fire district without regard to objective loss experience relating thereto.
  - **(iv)**

- **(I)** Unfair discrimination prohibited by the provisions of this subparagraph includes discrimination based on race, color, and national or ethnic origin. In addition, in connection with any kind of insurance, it shall be an unfair and deceptive act or practice to refuse to insure or to refuse to continue to insure an individual; to limit the amount, extent, or kind of coverage available to an individual; or to charge an individual a different rate for the same coverage because of the race, color, or national or ethnic origin of that individual. The prohibitions of this division are in addition to and supplement any and all other provisions of Georgia law prohibiting such discrimination which were previously enacted and currently exist, or which may be enacted subsequently, and shall not be a limitation on such other provisions of law.

- **(II)** A violation of this division shall give rise to a civil cause of action for damages resulting from such violation including, but not limited to, all damages recoverable for breach of insuring agreements under Georgia law including damages for bad faith and attorney's fees and costs of litigation. A violation of this division shall also give rise to the awarding of punitive or exemplary damages in an amount as may be determined by the trier of fact if such violation is found to be intentional. The remedies provided in this division are in addition to and cumulative of all other remedies that may now or hereafter be provided by law.

- **(B)** Knowingly permitting or offering to make or making any contract of insurance or agreement as to the contract other than as plainly expressed in the contract issued thereon; paying, allowing, giving, or offering to pay, allow, or give directly or indirectly, as inducement to any contract of insurance, any rebate of premiums payable on the contract, any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the contract, except in accordance with an applicable rate filing, rating plan, or rating system filed with and approved by the Commissioner; giving, selling, purchasing, or offering to give, sell, or purchase as inducement to such insurance or in connection therewith any stocks, bonds, or other securities of any company, any dividends or profits accrued thereon, or anything of value whatsoever not specified in the contract; or receiving or accepting as inducement to contracts of insurance any rebate of premium payable on the contract, any special favor or advantage in the dividends or other benefit to accrue thereon, or any valuable consideration or inducement not specified in the contract.

- **(C)** Nothing in subparagraphs (A) and (B) of this paragraph shall be construed as including within the definition of discrimination or rebates any of the following practices:

- **(i)** In the case of any contract of life insurance or life 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 interest of the company and its policyholders;

- **(ii)** In the case of life or accident and sickness insurance policies issued on the industrial debit or weekly premium plan, making allowance in an amount which fairly represents the saving in collection expense to policyholders who

have continuously for a specified period made premium payments directly to an office of the insurer;

- **(iii)** Making a readjustment of the rate of premium for a policy based on the loss or expense experienced at the end of the first or any subsequent policy year of insurance thereunder, which adjustment may be made retroactive only for the policy year;
- **(iv)** Issuing life or accident and sickness insurance policies covering bona fide employees of the insurer at a rate less than the rate charged other persons in the same class;
- **(v)** Issuing life or accident and sickness policies on a salary-saving, payroll deduction, preauthorized, postdated, automatic check, or draft plan at a reduced rate commensurate with the savings made by the use of such plan;
- **(vi)** Paying commissions or other compensation to duly licensed agents or brokers or allowing or returning dividends, savings, or unabsorbed premium deposits to participating policyholders, members, or subscribers;
- **(vii)** Paying by an insurance agent of part or all of the commissions on public insurance to a nonprofit association of insurance agents which is affiliated with a recognized state or national insurance agents' association, which commissions are to be used in whole or in part for one or more civic enterprises;
- **(viii)** Paying for food or refreshments by an insurer or an agent, broker, or employee of an insurer for current or prospective clients during group sales presentations and group seminars, provided that no insurance or annuity applications or contracts are offered or accepted at such presentations or seminars;
- **(ix)** Paying for business meals and entertainment by an insurer or an agent, broker, or employee of an insurer, agent, or broker for current or prospective clients; or
- **(x)** Advertising or conducting promotional programs by insurers or insurance producers whereby prizes, goods, wares, store gift cards, gift certificates, sporting event tickets, or merchandise, not exceeding $100.00 in value per customer in the aggregate in any one calendar year, are given to current or prospective customers; provided, however, that the giving of any item or items of value under this subsection shall not be contingent on the sale or renewal of a policy;

- **(9)** Failing to instruct and require properly that agents shall, in the solicitation of insurance and the filling out of applications of insurance on behalf of policyholders, incorporate therein all material facts relevant to the risk being written, which facts are known to the agent or could have been known by proper diligence;
- **(10)** Encouraging agents to accept applications which contain material misrepresentations or conceal material information which, if stated in the application, would prevent issuance of the policy or which would void a policy from its inception according to its terms even though premiums had been paid on the policy;
- **(11)** Any insurer or agent of same becoming a party to requiring or imposing as a condition to the sale of real or personal property or to the financing of real

or personal property, as a condition to the granting of or an extension of a loan which is to be secured by the title to or a lien of any kind on real or personal property, or as a condition to the performance of any other act in connection with the sale, financing, or lending, whether the person thus acts for himself or for anyone else, that the insurance or any renewal thereof to be issued on said property as collateral to said sale or loan shall be written through any particular insurance company or agent, provided that this paragraph shall not apply to a policy purchased by the seller, financier, or lender from his or its own funds and not charged to the purchaser or borrower in the sale price of the property or the amount of the loan or required to be paid for out of his personal funds; provided, further, that such seller, financier, or lender may disapprove for reasons affecting solvency or other sensible and sufficient reasons, the insurance company selected by the buyer or borrower. This paragraph shall not apply to title insurance;

- **(12)**
  - **(A)** Representing that any insurer or agent is employed by or otherwise associated with any Medicare program as defined in Code Section 33-43-1 or the United States Social Security Administration or that any insurance policy sold or offered for sale has been endorsed or sponsored by the federal or state government.
  - **(B)** Knowingly selling or offering to sell Medicare supplement insurance coverage as defined in Code Section 33-43-1 which is not in compliance with the provisions of Chapter 43 of this title, relating to Medicare supplement insurance, or the rules and regulations promulgated by the Commissioner pursuant to Chapter 43 of this title.
  - **(C)** Representing that any individual policy is a group policy or that the insurer, agent, or policy is endorsed, sponsored by, or associated with any group, association, or other organization unless such is, in fact, the case.
  - **(D)** Knowingly selling to Medicaid recipients substantially unnecessary coverage which duplicates benefits provided under the Medicaid program without disclosing to the prospective buyer that it may not be to the buyer's benefit or that it might actually be to the buyer's detriment to purchase the additional coverage;
- **(13)**
  - **(A)** Making direct response advertising by an insurer, including radio or television advertisement, of any individual or group life insurance policy in which computation of the death benefit is of such a technical nature that such death benefit cannot reasonably be properly presented in the advertisement and understood by a member of the insuring public. Policies, other than variable life or other interest sensitive policies, which provide for multiple changes in death benefits, combinations of increasing and nonuniformly decreasing term insurance, or increasing life insurance benefits equal to or slightly greater than the premiums paid during the early years of the coverage combined with accidental death benefits are types of contracts within the purview of this subparagraph. Additionally, any life insurance policy which cannot be truthfully, completely, clearly, and accurately disclosed in an advertisement falls within this subparagraph.

- **(B)** Making direct response advertising by an insurer, including radio or television advertisement, of any individual or group accident and sickness or life insurance policy which is misleading in fact or by implication that the coverage is "guaranteed issue" when there are conditions to be met by those persons to be insured, such as limited medical questions or other underwriting guidelines of the insurer.
- **(C)** Making direct response advertising by an insurer, including radio or television advertisement, of any individual or group accident and sickness or life insurance policy where such advertisement has not been approved for use in this state by the Commissioner;

○ **(14)** Failing to disclose in printed advertising material that medical benefits are calculated on the basis of usual, customary, and reasonable charges;

○ **(14.1)** Engaging in dishonest, unfair, or deceptive insurance practices in marketing or sales of insurance to service members of the armed forces of the United States and, notwithstanding any other provision of this title, the Commissioner may promulgate such rules and regulations as necessary to define dishonest, unfair, or deceptive military marketing and sales practices;

○ **(14.2)** Failing to submit all claims data to the Georgia All-Payer Claims Database as required in Article 3 of Chapter 53 of Title 31;

○ **(14.3)**

- **(A)** As used in this paragraph:
- **(i)** "Covered eye care services" means those health care services and materials related to the care of the eye and related structures and vision care services which a health care insurer is obligated to pay for or provide to covered persons under an eye care benefit plan, which includes services for which reimbursement is available under such plan, or for which reimbursement would be available but for the application of contractual limitations such as deductibles, copayments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation.
- **(ii)** "Covered person" means any subscriber, enrollee, member, beneficiary, or participant, or his or her dependent, for whom benefits are payable when such person receives eye care services rendered or authorized by an ophthalmologist licensed under Chapter 34 of Title 43 or an optometrist licensed under Chapter 30 of Title 43.
- **(iii)** "Eye care benefit plan" means any individual or group plan, policy contract, or subscription agreement which includes or is for eye care services that is issued, delivered, issued for delivery, or renewed in this state whether by a health care insurer, health maintenance organization, preferred provider organization, accident and sickness insurer, fraternal benefit society, nonprofit hospital service corporation, nonprofit medical or eye care service corporation, health care plan, or any other person, firm, corporation, joint venture, or other similar business entity that pays for, purchases, or furnishes eye care services to patients, insureds, beneficiaries, or covered dependents in this state.

- **(iv)** "Health care insurer" or "insurer" means an entity, including but not limited to insurance companies, health care corporations, health maintenance organizations, and preferred provider organizations, authorized by the state to offer or provide health benefit plans, eye care benefit plans, programs, policies, subscriber contracts, or any other agreements of a similar nature which compensate or indemnify health care providers for furnishing covered eye care or other health care services.

- **(B)** No insurer shall require an ophthalmologist or optometrist to accept as payment an amount set by such insurer for services that are not covered eye care services under the covered person's eye care benefit plan as a condition to join or participate in its provider network.

- **(C)** No insurer shall draft, publish, disseminate, or circulate any explanations of benefit forms that include language that directly or indirectly states or implies that an ophthalmologist or optometrist should extend discounts to patients for noncovered eye care services.

- **(D)** No insurer shall require an ophthalmologist or optometrist within its provider network to extend any discounts on services that are not covered eye care services.

- **(E)** No insurer shall require an ophthalmologist or optometrist to extend any discounts on services that are not covered eye care services in order to receive increased payments, better reimbursements, preferential treatment, or any other benefit; or

- **(15)**

- **(A)** As used in this paragraph, the term:

- **(i)** "Confidential abuse information" means information about acts of family violence or sexual assault, the status of a victim of family violence or sexual assault, an individual's medical condition that the insurer knows or has reason to know is related to family violence or sexual assault, or the home and work addresses and telephone numbers of a subject of family violence or sexual assault.

- **(ii)** "Family violence" means family violence as defined in Code Sections 19-13-1 and 19-13-20 and as limited by Code Section 19-13-1.

- **(iii)** "Sexual assault" means rape, sodomy, aggravated sodomy, sexual battery, and aggravated sexual battery as those terms are defined in Chapter 6 of Title 16.

- **(B)** No person shall deny or refuse to accept an application; refuse to insure; refuse to renew; refuse to reissue; cancel, restrict, or otherwise terminate; charge a different rate for the same coverage; add a premium differential; or exclude or limit coverage for losses or deny a claim incurred by an insured on the basis that the applicant or insured is or has been a victim of family violence or sexual assault or that such person knows or has reason to know the applicant or insured may be a victim of family violence or sexual assault; nor shall any person take or fail to take any of the

aforesaid actions on the basis that an applicant or insured provides shelter, counseling, or protection to victims of family violence or sexual assault.

- **(C)** No person shall request, directly or indirectly, any information the person knows or reasonably should know relates to acts of family violence or sexual assault or an applicant's or insured's status as a victim of family violence or sexual assault or make use of such information however obtained, except for the limited purpose of complying with legal obligations, verifying an individual's claim to be a subject of family violence or sexual assault, cooperating with a victim of family violence or sexual assault in seeking protection from family violence or sexual assault, or facilitating the treatment of a family violence or sexual assault related medical condition. When a person has information in their possession that clearly indicates that the insured or applicant is a subject of family violence or sexual assault, the disclosure or transfer of the information by a person to any person, entity, or individual is a violation of this Code section, except:

- **(i)** To the subject of family violence or sexual assault or an individual specifically designated in writing by the subject of family violence or sexual assault;

- **(ii)** To a health care provider for the direct provision of health care services;

- **(iii)** To a licensed physician identified and designated by the subject of family violence or sexual assault;

- **(iv)** When ordered by the Commissioner or a court of competent jurisdiction or otherwise required by law;

- **(v)** When necessary for a valid business purpose to transfer information that includes confidential abuse information that cannot reasonably be segregated without undue hardship. Confidential abuse information may be disclosed pursuant to this division only to the following persons or entities, all of whom shall be bound by this subparagraph:

- **(I)** A reinsurer that seeks to indemnify or indemnifies all or any part of a policy covering a subject of family violence or sexual assault and that cannot underwrite or satisfy its obligations under the reinsurance agreement without that disclosure;

- **(II)** A party to a proposed or consummated sale, transfer, merger, or consolidation of all or part of the business of the person;

- **(III)** Medical or claims personnel contracting with the person, only where necessary to process an application or perform the person's duties under the policy or to protect the safety or privacy of a subject of family violence or sexual assault; or

- **(IV)** With respect to address and telephone number, to entities with whom the person transacts business when the business cannot be transacted without the address and telephone number;

- **(vi)** To an attorney who needs the information to represent the person effectively, provided the person notifies the attorney of its obligations under this paragraph and requests that the attorney exercise due diligence to protect the confidential abuse information consistent with the attorney's obligation to represent the person;
- **(vii)** To the policy owner or assignee, in the course of delivery of the policy, if the policy contains information about family violence or sexual assault status; or
- **(viii)** To any other entities deemed appropriate by the Commissioner.
- **(D)** It is unfairly discriminatory to terminate group coverage for a subject of family violence because coverage was originally issued in the name of the perpetrator of the family violence and the perpetrator has divorced, separated from, or lost custody of the subject of family violence, or the perpetrator's coverage has terminated voluntarily or involuntarily. If termination results from an act or omission of the perpetrator, the subject of family violence shall be deemed a qualifying eligible individual under Code Section 33-24-21.1 and may obtain continuation and conversion of such coverages notwithstanding the act or omission of the perpetrator. A person may request and receive confidential abuse information to implement the continuation and conversion of coverages under this subparagraph.
- **(E)** Subparagraph (C) of this paragraph shall not preclude a subject of family violence or sexual assault from obtaining his or her insurance records. Subparagraph (C) of this paragraph shall not prohibit a person from asking about a medical condition or a claims history or from using medical information or a claims history to underwrite or to carry out its duties under the policy to the extent otherwise permitted under this paragraph and other applicable law.
- **(F)** No person shall take action that adversely affects an applicant or insured on the basis of a medical condition, claim, or other underwriting information that the person knows or has reason to know is family violence or sexual assault related and which:
- **(i)** Has the purpose or effect of treating family violence or sexual assault status as a medical condition or underwriting criterion;
- **(ii)** Is based upon correlation between a medical condition and family violence or sexual assault;
- **(iii)** Is not otherwise permissible by law and does not apply in the same manner and to the same extent to all applicants and insureds similarly situated without regard to whether the condition or claim is family violence or sexual assault related; or
- **(iv)** Except for claim actions, is not based on a determination, made in conformance with sound actuarial and underwriting principles and guidelines generally applied in the insurance industry and supported by reasonable statistical evidence, that there is a correlation between the applicant's or insured's circumstances and a material increase in insurance risk.

- **(G)** No person shall fail to pay losses arising out of family violence or sexual assault against an innocent first-party claimant to the extent of such claimant's legal interest in the covered property, if the loss is caused by the intentional act of an insured against whom a family violence or sexual assault complaint is brought for the act causing this loss.
- **(H)** No person shall use other exclusions or limitations on coverage which the Commissioner has determined through the policy filing and approval process to unreasonably restrict the ability of victims of family violence or sexual assault to be indemnified for such losses.
- **(I)** Any person issuing, delivering, or renewing a policy of insurance in this state at any time shall include with such policy or renewal certificate a notice attached thereto containing the following language:

"NOTICE

The laws of the State of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence."

- **(c)** Any person violating this Code section by making unlawful, false representations as to the policy sold shall be guilty of a misdemeanor.

Amended by 2023 Ga. Laws 234,§ 1, eff. 7/1/2023, app. to all policies or contracts issued, delivered, issued for delivery, or renewed in this state on or after 7/1/2023.

Amended by 2022 Ga. Laws 782,§ 33, eff. 5/2/2022.

Amended by 2021 Ga. Laws 248,§ 2, eff. 7/1/2021.

Amended by 2020 Ga. Laws 580,§ 2, eff. 8/5/2020.

Amended by 2019 Ga. Laws 273,§ 1, eff. 7/1/2019.

Amended by 2019 Ga. Laws 139,§ 1-34, eff. 7/1/2019.

Amended by 2016 Ga. Laws 444,§ 1, eff. 7/1/2016.

Amended by 2007 Ga. Laws 254,§ 1, eff. 5/24/2007.

Amended by 2006 Ga. Laws 584,§ 1, eff. 7/1/2006.

Amended by 2006 Ga. Laws 453,§ 33, eff. 4/14/2006.

Amended by 2005 Ga. Laws 108,§ 2, eff. 7/1/2005.

Amended by 2001 Ga. Laws 2, § 33, eff. 2/12/2001.

See 2021 Ga. Laws 248, § 3.

Georgia Code § 33-23-35

2023 CODE OF GEORGIA
Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)
Chapter 23 - LICENSING OF AGENTS, AGENCIES, SUBAGENTS, COUNSELORS, AND ADJUSTERS (§§ 33-23-1 — 33-23-205)

Article 1 - AGENTS, AGENCIES, SUBAGENTS, COUNSELORS, AND ADJUSTERS (§§ 33-23-1 — 33-23-46)
Section 33-23-1 - Definitions

Universal Citation:

GA Code § 33-23-1 (2023)

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Next

- **(a)** As used in this article, the term:
  - **(1)** "Adjuster" means any individual who for a fee, commission, salary, or other compensation investigates, settles, or adjusts and reports to his or her employer or principal with respect to claims arising under insurance contracts on behalf of the insurer or the insured or a person who directly supervises or manages such individual. The term "adjuster" does not include:
    - **(A)** Individuals who adjust claims arising under contracts of life or marine insurance or annuities; or
    - **(B)** An agent or a salaried employee of an agent or a salaried employee of an insurer who adjusts or assists in adjusting losses under policies issued by such agent or insurer.
  - **(2)** "Agency" means a business entity which represents one or more insurers and is engaged in the business of selling, soliciting, or negotiating insurance. Agency also means a business entity insurance producer.
  - **(3)** "Agent" means an individual appointed or employed by an insurer who sells, solicits, or negotiates insurance. Agent also means an individual insurance producer.
  - **(3.1)** "Automated claims adjudication system" means a preprogrammed computer system designed for the collection, data entry, calculation, and final resolution of property insurance claims used only for portable electronics as defined in paragraph (1) of subsection (d) of Code Section 33-23-12 which:
    - **(A)** May only be utilized by a licensed independent adjuster, licensed agent, or supervised individuals operating pursuant to this paragraph;
    - **(B)** Shall comply with all claims payment requirements of the Georgia Insurance Code; and
    - **(C)** Shall be certified as compliant with this Code section by a licensed independent adjuster that is an officer of a business entity licensed under this chapter.
  - **(4)** "Business entity" means a corporation, association, partnership, sole proprietorship, limited liability company, limited liability partnership, or other legal entity.
  - **(5)** "Controlled business of a person" means property or casualty insurance for a person or a person's spouse; for any relative by blood or marriage within

the second degree of kinship as defined by paragraph (5) of Code Section 53-4-2; for a person's employer or the firm of which a person is a member; for any officer, director, stockholder, or member of a person's employer or of any firm of which a person is a partner; for any spouse of the officer, director, employer, stockholder, or member of a person's firm; for a person's ward or employee; or for any person or in regard to any property under a person's control or supervision in any fiduciary capacity.

- **(6)** "Counselor" means any individual who engages or advertises or holds himself or herself out as engaging in the business of counseling, advising, or rendering opinions as to the benefits promised under any contract of insurance issued or offered by any insurer or as to the terms, value, effect, advantages, or disadvantages under the contract of insurance, other than an actuary or consultant advising insurers. When receiving a fee, commission, or other compensation for this service, such individual shall not receive any compensation from any other source on or relating to the same transaction.

- **(7)** "Home state" means Canada, the District of Columbia, and any state or territory of the United States in which an insurance producer or adjuster maintains his or her principal place of residence or principal place of business and is licensed to act as an insurance producer or adjuster.

- **(8)** "Independent adjuster" means an adjuster representing the interest of the insurer who is not an employee of such insurer.

- **(9)** "Insurance," except where the type of insurance is specifically stated, means all kinds of insurance other than bail bonding by individual sureties.

- **(10)** "Insurance producer" means a person required to be licensed under the laws of this state to sell, solicit, or negotiate insurance.

- **(10.1)** "Limited subagent" means an individual licensed on behalf of a licensed agent pursuant to Code Section 33-23-12.

- **(11)** "Negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms, or conditions of the contract, provided that the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers.

- **(12)** "Person" means an individual or business entity.

- **(13)** "Public adjuster" means any person who solicits, advertises for, or otherwise agrees to represent only a person who is insured under a policy covering fire, windstorm, water damage, and other physical damage to real and personal property other than vehicles licensed for the road, and any such representation shall be limited to the settlement of a claim or claims under the policy for damages to real and personal property, including related loss of income and living expense losses but excluding claims arising out of any motor vehicle accident, and who, for compensation on behalf of an insured:

  - **(A)** Acts or aids, solely in relation to first-party claims arising under insurance contracts that insure the real or personal property of the insured, in

negotiating for, or effecting the settlement of, a claim for loss or damage covered by an insurance contract;

- **(B)** Advertises for employment as a public adjuster of insurance claims or solicits business or represents himself or herself to the public as a public adjuster of first-party claims for losses or damages arising out of policies of insurance that insure real or personal property; or
- **(C)** Directly or indirectly solicits business, investigates or adjusts losses, or advises an insured about first-party claims for losses or damages arising out of policies of insurance that insure real or personal property for another person engaged in the business of adjusting losses or damages covered by an insurance policy.

○ **(14)** "Sell" means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurance company.

○ **(15)** "Solicit" means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular company.

○ **(16)** "Subagent" means any licensed agent, except as provided in Code Section 33-23-12, who acts for or on behalf of another licensed agent in the selling of, solicitation of, or negotiation for an insurance contract or annuity contract and who has on file with the Commissioner a certificate of authority from each agent with whom the subagent places insurance. Subagent also means subproducer. The term "subagent" shall not include:

- **(A)** An agent who places insurance with or through another agent involving 12 or fewer policies or certificates of insurance in any one calendar year; or
- **(B)** An agent who places surplus lines insurance with or through a surplus lines broker only with respect to such surplus lines insurance.

○ **(17)** "Surplus lines broker" means an individual licensed pursuant to Code Section 33-23-37.

• **(b)** The definitions of agent, subagent, and counselor in subsection (a) of this Code section shall not be deemed to include:

○ **(1)** An attorney at law admitted to practice in this state, when handling the collections of premiums or advising clients as to insurance as a function incidental to the practice of law or who adjusts losses which are incidental to the practice of his or her profession;

○ **(2)** Any representative of ocean marine insurers;

○ **(3)** Any representative of farmers' mutual fire insurance companies as defined in Chapter 16 of this title;

○ **(4)** A salaried employee of a credit or character reporting firm or agency not engaged in the insurance business who may, however, report to an insurer;

○ **(5)** A person acting for or as a collection agency;

○ **(6)** A person who makes the salary deductions of premiums for employees or, under a group insurance plan, a person who serves the master policyholder of group

insurance in administering the details of such insurance for the employees or debtors of the master policyholder or of a firm or corporation by which the person is employed and who does not receive insurance commissions for such service; provided, further, that an administration fee not exceeding 5 percent of the premiums collected paid by the insurer to the administration office shall not be construed to be an insurance commission;

- **(7)** Persons exempted from licensure as provided in subsection (h) of Code Section 33-23-4; or
- **(8)** An individual who collects claim information from, or furnishes claim information to, insureds or claimants, who conducts data entry, and who enters data into an automated claims adjudication system, provided that the individual is an employee of a licensed independent adjuster or its affiliate where no more than 25 such persons are under the supervision of one licensed independent adjustor or licensed agent.

- **(c)** In addition to paragraphs (2) through (8) of subsection (b) of this Code section, the definitions of public adjuster, independent adjuster, and adjuster in subsection (a) of this Code section shall not be deemed to include an attorney admitted to practice law in this state.

Amended by 2014 Ga. Laws 504,§ 1 and § 2, eff. 7/1/2014.

Amended by 2012 Ga. Laws 776,§ 5, eff. 7/1/2012.

Amended by 2012 Ga. Laws 776,§ 4, eff. 7/1/2012.

Amended by 2012 Ga. Laws 776,§ 3, eff. 7/1/2012.

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Amended by 2008 Ga. Laws 767,§ 1, eff. 7/1/2008.

Amended by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Georgia Code § 33-23-35

2023 CODE OF GEORGIA
Title 33 - INSURANCE (§§ 33-1-1 — 33-66-8)
Chapter 23 - LICENSING OF AGENTS, AGENCIES, SUBAGENTS, COUNSELORS, AND ADJUSTERS (§§ 33-23-1 — 33-23-205)
Article 1 - AGENTS, AGENCIES, SUBAGENTS, COUNSELORS, AND ADJUSTERS (§§ 33-23-1 — 33-23-46)
Section 33-23-1 - Definitions

Universal Citation:

GA Code § 33-23-1 (2023)

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Next

- **(a)** As used in this article, the term:
  - **(1)** "Adjuster" means any individual who for a fee, commission, salary, or other compensation investigates, settles, or adjusts and reports to his or her employer or principal with respect to claims arising under insurance contracts on behalf of the insurer or the insured or a person who directly supervises or manages such individual. The term "adjuster" does not include:
    - **(A)** Individuals who adjust claims arising under contracts of life or marine insurance or annuities; or
    - **(B)** An agent or a salaried employee of an agent or a salaried employee of an insurer who adjusts or assists in adjusting losses under policies issued by such agent or insurer.
  - **(2)** "Agency" means a business entity which represents one or more insurers and is engaged in the business of selling, soliciting, or negotiating insurance. Agency also means a business entity insurance producer.
  - **(3)** "Agent" means an individual appointed or employed by an insurer who sells, solicits, or negotiates insurance. Agent also means an individual insurance producer.
  - **(3.1)** "Automated claims adjudication system" means a preprogrammed computer system designed for the collection, data entry, calculation, and final resolution of property insurance claims used only for portable electronics as defined in paragraph (1) of subsection (d) of Code Section 33-23-12 which:
    - **(A)** May only be utilized by a licensed independent adjuster, licensed agent, or supervised individuals operating pursuant to this paragraph;
    - **(B)** Shall comply with all claims payment requirements of the Georgia Insurance Code; and
    - **(C)** Shall be certified as compliant with this Code section by a licensed independent adjuster that is an officer of a business entity licensed under this chapter.
  - **(4)** "Business entity" means a corporation, association, partnership, sole proprietorship, limited liability company, limited liability partnership, or other legal entity.
  - **(5)** "Controlled business of a person" means property or casualty insurance for a person or a person's spouse; for any relative by blood or marriage within the second degree of kinship as defined by paragraph (5) of Code Section 53-4-2; for a person's employer or the firm of which a person is a member; for any officer, director, stockholder, or member of a person's employer or of any firm of which a person is a partner; for any spouse of the officer, director, employer, stockholder, or member of a person's firm; for a person's ward or employee; or for any person or in regard to any property under a person's control or supervision in any fiduciary capacity.
  - **(6)** "Counselor" means any individual who engages or advertises or holds himself or herself out as engaging in the business of counseling, advising, or rendering

opinions as to the benefits promised under any contract of insurance issued or offered by any insurer or as to the terms, value, effect, advantages, or disadvantages under the contract of insurance, other than an actuary or consultant advising insurers. When receiving a fee, commission, or other compensation for this service, such individual shall not receive any compensation from any other source on or relating to the same transaction.

- **(7)** "Home state" means Canada, the District of Columbia, and any state or territory of the United States in which an insurance producer or adjuster maintains his or her principal place of residence or principal place of business and is licensed to act as an insurance producer or adjuster.
- **(8)** "Independent adjuster" means an adjuster representing the interest of the insurer who is not an employee of such insurer.
- **(9)** "Insurance," except where the type of insurance is specifically stated, means all kinds of insurance other than bail bonding by individual sureties.
- **(10)** "Insurance producer" means a person required to be licensed under the laws of this state to sell, solicit, or negotiate insurance.
- **(10.1)** "Limited subagent" means an individual licensed on behalf of a licensed agent pursuant to Code Section 33-23-12.
- **(11)** "Negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms, or conditions of the contract, provided that the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers.
- **(12)** "Person" means an individual or business entity.
- **(13)** "Public adjuster" means any person who solicits, advertises for, or otherwise agrees to represent only a person who is insured under a policy covering fire, windstorm, water damage, and other physical damage to real and personal property other than vehicles licensed for the road, and any such representation shall be limited to the settlement of a claim or claims under the policy for damages to real and personal property, including related loss of income and living expense losses but excluding claims arising out of any motor vehicle accident, and who, for compensation on behalf of an insured:
  - **(A)** Acts or aids, solely in relation to first-party claims arising under insurance contracts that insure the real or personal property of the insured, in negotiating for, or effecting the settlement of, a claim for loss or damage covered by an insurance contract;
  - **(B)** Advertises for employment as a public adjuster of insurance claims or solicits business or represents himself or herself to the public as a public adjuster of first-party claims for losses or damages arising out of policies of insurance that insure real or personal property; or
  - **(C)** Directly or indirectly solicits business, investigates or adjusts losses, or advises an insured about first-party claims for losses or damages arising out

of policies of insurance that insure real or personal property for another person engaged in the business of adjusting losses or damages covered by an insurance policy.

- **(14)** "Sell" means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurance company.
- **(15)** "Solicit" means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular company.
- **(16)** "Subagent" means any licensed agent, except as provided in Code Section 33-23-12, who acts for or on behalf of another licensed agent in the selling of, solicitation of, or negotiation for an insurance contract or annuity contract and who has on file with the Commissioner a certificate of authority from each agent with whom the subagent places insurance. Subagent also means subproducer. The term "subagent" shall not include:
  - **(A)** An agent who places insurance with or through another agent involving 12 or fewer policies or certificates of insurance in any one calendar year; or
  - **(B)** An agent who places surplus lines insurance with or through a surplus lines broker only with respect to such surplus lines insurance.
- **(17)** "Surplus lines broker" means an individual licensed pursuant to Code Section 33-23-37.

- **(b)** The definitions of agent, subagent, and counselor in subsection (a) of this Code section shall not be deemed to include:
  - **(1)** An attorney at law admitted to practice in this state, when handling the collections of premiums or advising clients as to insurance as a function incidental to the practice of law or who adjusts losses which are incidental to the practice of his or her profession;
  - **(2)** Any representative of ocean marine insurers;
  - **(3)** Any representative of farmers' mutual fire insurance companies as defined in Chapter 16 of this title;
  - **(4)** A salaried employee of a credit or character reporting firm or agency not engaged in the insurance business who may, however, report to an insurer;
  - **(5)** A person acting for or as a collection agency;
  - **(6)** A person who makes the salary deductions of premiums for employees or, under a group insurance plan, a person who serves the master policyholder of group insurance in administering the details of such insurance for the employees or debtors of the master policyholder or of a firm or corporation by which the person is employed and who does not receive insurance commissions for such service; provided, further, that an administration fee not exceeding 5 percent of the premiums collected paid by the insurer to the administration office shall not be construed to be an insurance commission;
  - **(7)** Persons exempted from licensure as provided in subsection (h) of Code Section 33-23-4; or

- **(8)** An individual who collects claim information from, or furnishes claim information to, insureds or claimants, who conducts data entry, and who enters data into an automated claims adjudication system, provided that the individual is an employee of a licensed independent adjuster or its affiliate where no more than 25 such persons are under the supervision of one licensed independent adjustor or licensed agent.

- **(c)** In addition to paragraphs (2) through (8) of subsection (b) of this Code section, the definitions of public adjuster, independent adjuster, and adjuster in subsection (a) of this Code section shall not be deemed to include an attorney admitted to practice law in this state.

Amended by 2014 Ga. Laws 504,§ 1 and § 2, eff. 7/1/2014.

Amended by 2012 Ga. Laws 776,§ 5, eff. 7/1/2012.

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Amended by 2012 Ga. Laws 727,§ 4, eff. 7/1/2012.

Amended by 2008 Ga. Laws 767,§ 1, eff. 7/1/2008.

Amended by 2001 Ga. Laws 293, § 1, eff. 7/1/2002.

Chapter 38. Georgia Life and Health Insurance Guaranty Association

GA CODE § 33-38-1

The purpose of this chapter is to protect the persons specified in subsection (b) of Code Section 33-38-2, subject to certain limitations, against failure in the performance of contractual obligations, under life, health, and annuity policies, plans, or contracts specified in subsection (a) of Code Section 33-38-2, due to the impairment or insolvency of the member insurer issuing such policies, plans, or contracts. To provide this protection: (1) an association of member insurers is created to enable the guaranty of payment of benefits and continuation of coverages as limited by this chapter; (2) members of the association are subject to assessment to provide funds to carry out the purpose of this chapter; and (3) the association is authorized to assist the Commissioner, in the prescribed manner, in the detection and prevention of insurer impairments or insolvencies.

GA CODE § 33-38-2

(a) This chapter shall provide coverage to the persons specified in subsection (b) of this Code section for policies or contracts of direct, nongroup life insurance; health insurance which for the purposes of this chapter includes health maintenance organization subscriber contracts and certificates and health care plans issued by health care corporations; annuities; for certificates under direct group policies and

contracts and supplemental contracts to any of these; and for unallocated annuity contracts, in each case issued by member insurers, except as limited by this chapter. Annuity contracts and certificates under group annuity contracts include, but are not limited to, guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement annuities, annuities issued to or in connection with government lotteries, and any immediate or deferred annuity contracts.

(b)(1) Coverage under this chapter shall be provided only:

(A) To persons who, regardless of where they reside, except for nonresident certificate holders under group policies or contracts, are the beneficiaries, assignees, or payees, including health care providers rendering services covered under health insurance policies or certificates, of the persons covered under subparagraph (B) of this paragraph; and

(B) To persons who are owners of or certificate holders or enrollees under such policies or contracts, other than unallocated annuity contracts and structured settlement annuities, to the persons who are the contract holders and who:

(i) Are residents; or

(ii) Are not residents, but the member insurers which issued such policies or contracts are domiciled in this state; the states in which such persons reside have associations similar to the association created by this chapter; and such persons are not eligible for coverage by an association in any other state due to the fact that the insurer, health maintenance organization, or health care corporation was not licensed in the state at the time specified in the state's guaranty association law.

(2) For unallocated annuity contracts specified in subsection (a) of this Code section, subparagraphs (A) and (B) of paragraph (1) of this subsection shall not apply, and this chapter shall, except as provided in paragraphs (4) and (5) of this subsection, provide coverage to:

(A) Persons who are the owners of the unallocated annuity contracts if the contracts are issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of business in this state; and

(B) Persons who are owners of unallocated annuity contracts issued to or in connection with government lotteries if the owners are residents.

(3) For structured settlement annuities specified in subsection (a) of this Code section, subparagraphs (A) and (B) of paragraph (1) of this subsection shall not apply, and this chapter shall, except as provided in paragraphs (4) and (5) of this subsection, provide coverage to a person who is a payee under a structured settlement annuity, or beneficiary of a payee if the payee is deceased, if the payee:

(A) Is a resident, regardless of where the contract owner resides; or

(B) Is not a resident, but only under both of the following conditions:

(i)(I) The contract owner of the structured settlement annuity is a resident; or

(II) The contract owner of the structured settlement annuity is not a resident, but the insurer that issued the structured settlement annuity is domiciled in this state and the state in which the contract owner resides has an association similar to the association created by this chapter; and

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

(4) This chapter shall not provide coverage to:

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

(B) A person covered under paragraph (2) of this subsection, if any coverage is provided by the association of another state to that person; or

(C) A person who acquires rights to receive payments through a structured settlement factoring transaction, as such term is defined in 26 U.S.C. Section 5891(c)(3)(A) as such term existed on January 23, 2002, regardless of whether the transaction occurred before or after such date.

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

(c) Except as otherwise provided in subsection (d) of this Code section, this chapter shall not provide coverage to:

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

(2) A policy or contract of reinsurance or any policy or contract or part thereof assumed by the impaired or insolvent insurer under a contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract;

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

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

member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier; and

(B) On and after the date on which the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier, exceeds the rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average as most recently available;

(4) Any prepaid legal services plan, as defined in Code Section 33-35-2;

(5) Any policy, contract, or certificate issued by a fraternal benefit society, as defined in Code Section 33-15-1;

(6) Accident and sickness insurance as defined in Code Section 33-7-2 when written by a property and casualty insurer as part of an automobile insurance contract;

(7) A portion of a policy or contract issued to a plan or program of an employer, association, or other person to provide life, health, or annuity benefits to its employees, members, or others, to the extent that the plan or program is self-funded or uninsured, including, but not limited to, benefits payable by an employer, association, or other person under:

(A) A multiple employer welfare arrangement as defined in 29 U.S.C. Section 1002(40);

(B) A minimum premium group insurance plan;

(C) A stop-loss insurance policy; or

(D) An administrative services only contract;

(8) A portion of a policy or contract to the extent that it provides for:

(A) Dividends or experience rating credits;

(B) Voting rights; or

(C) Payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;

(9) A policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue the policy or contract in this state;

(10) Any unallocated annuity contract issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation, regardless of whether the federal Pension Benefit Guaranty Corporation has yet become liable to make any payments with respect to the benefit plan;

(11) Any portion of any unallocated annuity contract which is not issued to or in connection with a specific employee, union, or association of natural persons benefit plan or a government lottery;

(12) A portion of a policy or contract to the extent that the assessments required by Code Section 33-38-15 with respect to the policy or contract are preempted by federal or state law;

(13) An obligation that does not arise under the express written terms of the policy or contract issued by the member insurer to the enrollee, certificate holder, contract owner or policy owner, including without limitation:

(A) Claims based on marketing materials;

(B) Claims based on side letters, riders, or other documents that were issued by the member insurer without meeting applicable policy or contract form filing or approval requirements;

(C) Misrepresentations of or regarding policy or contract benefits;

(D) Extra-contractual claims; or

(E) A claim for penalties or consequential or incidental damages;

(14) A contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer;

(15) A portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this paragraph, the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and will not be subject to forfeiture;

(16) A policy or contract providing any hospital, medical, prescription drug, or other health care benefits pursuant to Part C or Part D of Subchapter XVIII, Chapter 7 of Title 42 of the United States Code, commonly known as Medicare Part C & D, Subchapter XIX, Chapter 7 of Title 42 of the United States Code (commonly known as Medicaid), or any regulations issued pursuant thereto; or

(17) Structured settlement annuity benefits to which a payee or beneficiary has transferred his or her rights in a structured settlement factoring transaction, as such term is defined in 26 U.S.C. Section 5891(c)(3)(A) as such term existed on January 23, 2002, regardless of whether the transaction occurred before or after such date.

(d) The exclusion from coverage referenced in paragraph (3) of subsection (c) of this Code section shall not apply to any portion of a policy or contract, including a rider, that provides long-term care for any other health insurance benefit.

(e) The provisions of this Code section shall apply only to coverage the Georgia Life and Health Insurance Guaranty Association provides in connection with any member insurer that is placed under an order of liquidation with a finding of insolvency on or after July 1, 2020.

GA CODE § 33-38-3

This chapter shall be construed to effect the purpose set forth in Code Section 33-38-1.

As used in this chapter, the term:

(1) “Account” means any of the two accounts created under Code Section 33-38-5.

(2) “Affiliate” means any person that directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with the person specified.

(3) “Association” means the Georgia Life and Health Insurance Guaranty Association created under Code Section 33-38-5.

(4) “Authorized assessment,” or “authorized” when used in the context of assessments, means a resolution by the board of directors of the association has been passed whereby an assessment will be called immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution is passed.

(5) “Benefit plan” means a specific employee, union, or association of natural persons benefit plan.

(6) “Called assessment,” or “called” when used in the context of assessments, means that a notice has been issued by the association to member insurers requiring that an authorized assessment be paid within the time frame set forth within the notice. An authorized assessment becomes a called assessment when notice is mailed by the association to member insurers.

(7) “Contractual obligation” means any obligation under a covered policy, contract, or certificate under a group policy or contract, or portion thereof for which coverage is provided under Code Section 33-38-2.

(8) “Control” or “controlled” 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 ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise.

(9) “Covered contract” or “covered policy” means a policy or contract or portion of a policy or contract for which coverage is provided under Code Section 33-38-2.

(10) “Extra-contractual claims” shall include, for example, any claim not authorized by, or outside the scope of, the underlying policy or contract to include any claim based on bad faith, punitive or exemplary damages, treble damages, prejudgment or postjudgment interest, attorney's fees, or costs of litigation.

(11) “Health benefit plan” means any hospital or medical expense policy or certificate, health maintenance organization subscriber contract, or any other similar health contract. This term does not include:

(A) Accident only insurance;

(B) Credit insurance;

(C) Dental only insurance;

(D) Vision only insurance;

(E) Medicare supplement insurance;

(F) Benefits for long-term care, home health care, community based care, or any combination thereof;

(G) Disability income insurance;

(H) Coverage for on-site medical clinics; or

(I) Specified disease, hospital confinement indemnity, or limited benefit health insurance if the types of coverage do not provide coordination of benefits and are provided under separate policies or certificates.

(12) “Health care corporation” means a corporation established in accordance with the provisions of Chapter 20 of Title 33 to administer one or more health care plans as defined in Code Section 33-20-3(4).

(13) “Impaired insurer” means a member insurer which is not an insolvent insurer and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(14) “Insolvent insurer” means a member insurer against which an order of liquidation containing a finding of insolvency has been entered by a court of competent jurisdiction.

(15) “Member insurer” means any insurer, health maintenance organization, or health care corporation which is licensed or which holds a certificate of authority to transact in this state any kind of insurance, health care plan, or health maintenance organization business for which coverage is provided under Code Section 33-38-2 and includes any insurer, health care corporation, or health maintenance organization whose license or certificate of authority in this state may have been suspended, revoked, not renewed, or voluntarily withdrawn, but does not include:

(A) A fraternal benefit society;

(B) A mandatory state pooling plan;

(C) A mutual assessment company or any entity that operates on an assessment basis;

(D) An insurance exchange;

(E) An organization that has a certificate or license limited to the issuance of charitable gift annuities under Code Sections 33-58-1 through 33-58-6; or

(F) Any entity similar to those described in subparagraphs (A) through (E) of this paragraph.

(16) “Moody's Corporate Bond Yield Average” means the Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto.

(17) “Owner” of a policy or contract, “policyholder,” “policy owner,” and “contract owner” mean the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and

properly recorded as the owner on the books of the member insurer. The terms “owner,” “contract owner,” “policyholder,” and “policy owner” shall not include persons with a mere beneficial interest in a policy or contract.

(18) “Person” means any individual, corporation, limited liability company, partnership, association, governmental body or entity, or voluntary organization.

(19) “Plan sponsor” means:

(A) The employer in the case of a benefit plan established or maintained by a single employer;

(B) The employee organization in the case of a benefit plan established or maintained by an employee organization; or

(C) In a case of a benefit plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan.

(20) “Premiums” means amounts or considerations, by whatever name called, received on covered policies or contracts, less returned premiums, considerations and deposits thereon and less dividends and experience credits. The term “premiums” shall not include:

(A) Amounts or considerations received for policies or contracts or for the portions of policies or contracts for which coverage is not provided under this chapter except that assessable premium shall not be reduced on account of paragraph (3) of subsection (c) of Code Section 33-38-2, relating to interest limitations, and paragraph (12) of Code Section 33-38-7, relating to limitations with respect to one individual, one participant, and one policy or contract owner;

(B) Premiums in excess of $5 million on an unallocated annuity contract; or

(C) With respect to multiple nongroup policies of life insurance owned by one owner, whether the policy or contract owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, premiums in excess of $5 million with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.

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

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

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

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

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

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

(vi) In the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the above factors.

However, in the case of a plan sponsor, if more than 50 percent of the participants in the benefit plan are employed in a single state, that state shall be deemed to be the principal place of business of the plan sponsor.

(B) The principal place of business of a plan sponsor of a benefit plan described in subparagraph (C) of paragraph (19) of this Code section shall be deemed to be the principal place of business of the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, shall be deemed to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question.

(22) “Receivership court” means the court in the insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation, or liquidation of the member insurer.

(23) “Resident” means any person who resides in this state at the time a member insurer is determined to be an impaired or insolvent insurer and to whom contractual obligations are owed. A person may be a resident of only one state, which, in the case of a person other than a natural person, shall be its principal place of business. Citizens of the United States who are either residents of foreign countries or residents of United States possessions, territories, or protectorates that do not have an association similar to the association created by this chapter shall be deemed residents of the state of domicile of the member insurer that issued the policies or contracts.

(24) “State” means a state, the District of Columbia, Puerto Rico, and a United States possession, territory, or protectorate.

(25) “Structured settlement annuity” means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.

(26) “Supplemental contract” means a written agreement entered into for the distribution of proceeds under a life, health, or annuity policy or contract.

(27) “Unallocated annuity contract” means an annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate.

GA CODE § 33-38-5

(a) There is created a nonprofit, unincorporated association to be known as the Georgia

Life and Health Insurance Guaranty Association. All member insurers shall be and remain members of the association as a condition of their authority to transact insurance, a health maintenance organization business, or a health care corporation business in this state. The association shall perform its functions under the plan of operation established and approved under Code Section 33-38-8 and shall exercise its powers through a board of directors established under Code Section 33-38-6.

(b) The association shall come under the immediate supervision of the Commissioner and shall be subject to the applicable provisions of the insurance laws of this state.

(c) For purposes of administration and assessment, the association shall maintain two accounts: (1) the health insurance account; and (2) the life insurance and annuity account. The life insurance and annuity account shall contain three subaccounts: (A) the life insurance account; (B) the annuity account; and (C) the unallocated annuity account.

(d) For purposes of assessment, supplemental contracts shall be covered under the account in which the basic policy is covered.

GA CODE § 33-38-6

(a) The board of directors of the association shall consist of not less than seven nor more than 11 member insurers serving terms as established in the plan of operation. The members of the board shall be selected by the Commissioner from a list provided to the Commissioner from the board. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining board members, subject to the approval of the Commissioner.

(b) In approving selections of members to the board, the Commissioner shall consider, among other things, whether all member insurers are fairly represented.

(c) Members of the board may be reimbursed from the assets of the association for reasonable expenses incurred by them in their capacity as members of the board of directors, but members of the board shall not otherwise be compensated by the association for their services.

GA CODE § 33-38-7

(a) In addition to the powers and duties enumerated elsewhere in this chapter, the association shall have the following powers and duties:

(1) If a member insurer is an impaired insurer, the association, subject to any conditions, other than those conditions which impair the contractual obligations of the impaired insurer, imposed by the association and approved by the Commissioner, may, in its discretion:

(A) Guarantee, assume, reissue, or reinsure, or cause to be guaranteed, assumed, reissued, or reinsured, any or all of the covered policies or contracts of the impaired insurer; and

(B) Provide such moneys, pledges, loans, notes, guarantees, or other means as are proper to effectuate subparagraph (A) of this paragraph and assure payment of the contractual obligations of the impaired insurer pending action under subparagraph (A) of this paragraph; and

(2) If a member insurer is an insolvent insurer, the association shall, in its discretion, either:

(A)(i)(I) Guarantee, assume, reissue, or reinsure, or cause to be guaranteed, assumed, reissued, or reinsured, the covered policies or contracts of the insolvent insurer; or

(II) Assure payment of the contractual obligations of the insolvent insurer; and

(ii) Provide moneys, pledges, loans, notes, guarantees, or other means as are reasonably necessary to discharge the association's duties; or

(B) Provide benefits and coverages in accordance with the following provisions:

(i) With respect to policies and contracts, assure payment of benefits that would have been payable under the policies or contracts of the insolvent insurer, for claims incurred:

(I) With respect to group policies and contracts, not later than the earlier of the next renewal date under those policies or contracts or 45 days, but in no event less than 30 days, after the date on which the association becomes obligated with respect to the policies and contracts; and

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

(ii) Make diligent efforts to provide all known insureds, enrollees, or annuitants, for nongroup policies and contracts, or group policy or contract owners with respect to group policies and contracts, 30 days' notice of the termination, pursuant to division (i) of this subparagraph, of the benefits provided;

(iii) With respect to nongroup policies and contracts covered by the association, make available to each known insured, enrollee, or annuitant, or owner if other than the insured or annuitant, and with respect to an individual formerly an insured, enrollee, or annuitant under a group policy or contract who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of division (iv) of this subparagraph, if the insureds, enrollees, or annuitants had a right under law or the terminated policy, contract, or annuity to convert coverage to individual coverage or to continue an individual policy, contract, or annuity in force until a specified age or for a specified time, during which the insurer, health maintenance organization, or health care corporation had no right unilaterally to make changes in any provision of the policy, contract, or annuity or had a right only to make changes in premium by class;

(iv) In providing the substitute coverage required under division (iii) of this subparagraph, the association may offer either to reissue the terminated coverage or to issue an alternative policy or contract at actuarially justified rates, subject to the prior approval of the Commissioner. Alternative or reissued policies or contracts shall be

offered without requiring evidence of insurability and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy or contract. The association may reinsure any alternative or reissued policy or contract;

(v)(I) Alternative policies or contracts adopted by the association shall be subject to the approval of the Commissioner. The association may adopt alternative policies or contracts of various types for future issuance without regard to any particular impairment or insolvency.

(II) Alternative policies or contracts shall contain at least the minimum statutory provisions required in this state and provide benefits that shall not be unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates that it shall adopt. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but shall not reflect any changes in the health of the insured after the original policy was last underwritten.

(III) Any alternative policy or contract issued by the association shall provide coverage of a type similar to that of the policy or contract issued by the impaired or insolvent insurer, as determined by the association;

(vi) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy or contract, the premium shall be actuarially justified and set by the association in accordance with the amount of insurance or coverage provided and the age and class of risk, subject to prior approval of the Commissioner;

(vii) The association's obligations with respect to coverage under any policy or contract of the impaired or insolvent insurer or under any reissued or alternative policy or contract shall cease on the date the coverage, policy, or contract is replaced by another similar policy or contract by the policy or contract owner, the insured, the enrollee, or the association; and

(viii) When proceeding under this subparagraph with respect to a policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with paragraph (3) of subsection (c) of Code Section 33-38-2;

(3) Nonpayment of premiums within 31 days after the date required under the terms of any guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage shall terminate the association's obligations under the policy, contract or coverage under this chapter with respect to the policy, contract, or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of this chapter;

(4) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the association. The association shall be liable for unearned premiums due to policy or contract owners arising after the entry of the order;

(5) The protection provided by this chapter shall not apply where any guaranty protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state;

(6) In carrying out its duties under paragraph (2) of this Code section, the association may:

(A) Subject to approval by a court in this state, impose permanent policy or contract liens in connection with a guarantee, assumption, or reinsurance agreement, if the association finds that the amounts which can be assessed under this chapter are less than the amounts needed to assure full and prompt performance of the association's duties under this chapter, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of such permanent policy or contract liens, to be in the public interest; and

(B) Subject to approval by a court in this state, impose temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value. In addition, in the event of a temporary moratorium or moratorium charge imposed by the receivership court on payment of cash values or policy loans, or on any other right to withdraw funds held in conjunction with policies or contracts, out of the assets of the impaired or insolvent insurer, the association may defer the payment of cash values, policy loans, or other rights by the association for the period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court;

(7) A deposit in this state, held pursuant to law or required by the Commissioner for the benefit of creditors, including policy or contract owners, not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of an insurer domiciled in this state or in a reciprocal state, pursuant to Code Sections 33-3-8 through 33-3-10, shall be promptly paid to the association. The association shall be entitled to retain a portion of any amount so paid to it equal to the percentage determined by dividing the aggregate amount of policy or contract owners' claims related to that insolvency for which the association has provided statutory benefits by the aggregate amount of all policy or contract owners' claims in this state related to that insolvency and shall remit to the domiciliary receiver the amount so paid to the association less the amount retained pursuant to this paragraph. Any amount so paid to the association and retained by it shall be treated as a distribution of estate assets pursuant to applicable state receivership law dealing with early access disbursements.

(8) If the association fails to act within a reasonable period of time with respect to an insolvent insurer, as provided in paragraph (2) of this Code section, the Commissioner shall have the powers and duties of the association under this chapter with respect to the insolvent insurers;

(9) Upon the Commissioner's request, the association may render assistance and advice to the Commissioner concerning rehabilitation, payment of claims, continuance

of coverage, or the performance of other contractual obligations of any impaired or insolvent insurer;

(10) The association shall have standing to appear or intervene before any court or agency in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this chapter or with jurisdiction over any person or property against which the association may have rights through subrogation or otherwise. Such standing shall extend to all matters germane to the powers and duties of the association, including but not limited to proposals for reinsuring, reissuing, modifying, or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The association shall also have the right to appear or intervene before a court or agency in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over any person or property against whom the association may have rights through subrogation or otherwise;

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

(B) The subrogation rights of the association under this paragraph shall have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this chapter.

(C) In addition to subparagraphs (A) and (B) of this paragraph, the association shall have all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary, enrollee, or payee of a policy or contract with respect to the policy or contracts.

(D) If subparagraphs (A) through (C) of this paragraph are invalid or ineffective with respect to any person or claim for any reason, the amount payable by the association with respect to the related covered obligations shall be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies or contracts, or portion thereof, covered by the association.

(E) If the association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the association has rights as described in this paragraph, the person shall pay to the association the portion of the recovery attributable to the policies or contracts, or portion thereof, covered by the association;

(12) The benefits that the association may become obligated to cover shall in no event exceed the lesser of:

(A) The contractual obligations for which the member insurer is liable or would have been liable if it were not an impaired or insolvent insurer;

(B) With respect to one life, regardless of the number of policies or contracts:

(i) The amount of $300,000.00 in life insurance death benefits, but not more than $100,000.00 in net cash surrender and net cash withdrawal values for life insurance;

(ii) For health insurance benefits, $300,000.00 for disability income insurance; $300,000.00 for long-term care insurance; $300,000.00 for health insurance other than disability income insurance as referenced above, long-term care insurance as referenced above or health benefit plans as referenced below, including any net cash surrender and net cash withdrawal values; and $500,000.00 for health benefit plans; and

(iii) The amount of $300,000.00 in the present value of annuity benefits, but not more than $250,000.00 in net cash surrender and net cash withdrawal values for an annuity;

(C) With respect to each payee of a structured settlement annuity, or beneficiary or beneficiaries of the payee if deceased, $300,000.00 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any;

(D) However, in no event shall the association be obligated to cover more than:

(i) An aggregate of $300,000.00 in benefits with respect to any one life under subparagraphs (B) and (C) of this paragraph except with respect to benefits for health benefit plans under division (ii) of this subparagraph, in which case the aggregate liability of the association shall not exceed $500,000.00 with respect to any one individual; or

(ii) With respect to one owner of multiple nongroup policies of life insurance, whether the policy or contract owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, more than $5 million in benefits, regardless of the number of policies and contracts held by the owner;

(E) With respect to either one contract owner provided coverage under subparagraph (b)(2)(B) of Code Section 33-38-2 or one plan sponsor whose plans own directly or in trust one or more unallocated annuity contracts, $5 million in benefits, regardless of the number of contracts with respect to the contract owner or plan sponsor. However, in the case where one or more unallocated annuity contracts are covered contracts under this chapter and are owned by a trust or other entity for the benefit of two or more plan sponsors, coverage shall be afforded by the association if the largest interest in the trust or entity owning the contract or contracts is held by a plan sponsor whose principal place of business is in this state and in no event shall the association be obligated to cover more than $5 million in benefits with respect to all these unallocated contracts;

(F) The limitations set forth in this paragraph are limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the

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

(G) For purposes of this chapter, benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

(13) In performing its obligations to provide coverage under this Code section, the association shall not be required to guarantee, assume, reinsure, reissue, or perform, or cause to be guaranteed, assumed, reinsured, reissued, or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that does not materially affect the economic values or economic benefits of the covered policy or contract;

(14) In addition to the rights and powers elsewhere in this chapter, the association may:

(A) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this chapter;

(B) Sue or be sued, including the right to seek a declaratory judgment in any superior court of this state as to uncertainties with respect to the payment of benefits under this Code section. The association may also take any legal actions necessary or proper for recovery of any unpaid assessments under Code Section 33-38-15 and may settle claims or potential claims against it;

(C) Borrow money to effect the purposes of this chapter. Any notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic member insurers and may be carried as admitted assets;

(D) Employ or retain such persons as are necessary to handle the financial transactions of the association and to perform such other functions as become necessary or proper under this chapter;

(E) Negotiate and contract with any liquidator, rehabilitator, conservator, or ancillary receiver to carry out the powers and duties of the association;

(F) Take such legal action as may be necessary to avoid payment of improper claims; and

(G) Exercise, for the purposes of this chapter and to the extent approved by the Commissioner, the powers of a domestic life insurer, health insurer, health maintenance organization or health care corporation; but in no case may the association issue policies or contracts other than those issued to perform its obligations under this chapter;

(15) Organize itself as a corporation or in other legal form permitted by the laws of the state;

(16) Request information from a person seeking coverage from the association in order to aid the association in determining its obligations under this chapter with respect to the person, and the person shall promptly comply with the request;

(17) Unless prohibited by law, in accordance with the terms and conditions of the policy or contract, file for actuarially justified rate or premium increases for any policy or contract for which it provides coverage under this chapter;

(18) Take other necessary or appropriate action to discharge its duties and obligations under this chapter or to exercise its powers under this chapter;

(19) The association may join an organization of one or more other state associations of similar purposes, to further the purposes and administer the powers and duties of the association;

(20) With respect to covered policies for which the association becomes obligated after an entry of an order of liquidation, the association may elect to succeed to the rights of the insolvent insurer arising after the order of liquidation under any contract of reinsurance to which the insolvent insurer was a party, to the extent such contract provides coverage for losses occurring after the date of the order of liquidation. As a condition to making such election, the association must pay all unpaid premiums due under the contract for coverage relating to periods before and after the date on which the order of liquidation was entered;

(21) The board of directors shall have discretion and may exercise reasonable business judgment to determine the means by which the association is to provide the benefits of this chapter in an economical and efficient manner;

(22) Where the association has arranged or offered to provide the benefits of this chapter to a covered person under a plan or arrangement that fulfills the association's obligations under this chapter, the person shall not be entitled to benefits from the association in addition to or other than those provided under the plan or arrangement;

(23) Exclusive venue in any action by or against the association is in the Superior Court of DeKalb County. The association may, at its option, waive such venue as to specific actions. The association shall not be required to give an appeal bond in an appeal that relates to a cause of action arising under this chapter; and

(24) In carrying out its duties in connection with guaranteeing, assuming, reissuing, or reinsuring policies or contracts under paragraph (1) or (2) of this Code section, the association may issue substitute coverage for a policy or contract that provides an interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with the following provisions:

(A) In lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for a fixed interest rate, payment of dividends with minimum guarantees, or a different method for calculating interest or changes in value;

(B) There is no requirement for evidence of insurability, waiting period, or other exclusion that would not have applied under the replaced policy or contract; and

(C) The alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms.

(b) The provisions of this Code section shall apply only to coverage the Georgia Life and Health Insurance Guaranty Association provides in connection with any member insurer that is placed under an order of liquidation with a finding of insolvency on or after July 1, 2020.

GA CODE § 33-38-8

(a) The association shall submit to the Commissioner a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments thereto shall become effective upon approval in writing by the Commissioner. If the association fails to submit a suitable plan of operation or, if at any time thereafter the association fails to submit suitable amendments to the plan, the Commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this chapter. Such rules shall continue in force until modified by the Commissioner or superseded by a plan submitted by the association and approved in writing by the Commissioner.

(b) All member insurers shall comply with the plan of operation.

(c) The plan of operation shall, in addition to requirements enumerated elsewhere in this chapter:

(1) Establish procedures for handling the assets of the association;

(2) Establish the amount and method of reimbursing members of the board of directors under Code Section 33-38-6;

(3) Establish regular places and times for meetings of the board of directors;

(4) Establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors;

(5) Establish any additional procedures for assessments under Code Section 33-38-15; and

(6) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

GA CODE § 33-38-9

The plan of operation described in Code Section 33-38-8 may provide that any or all powers and duties of the association, except those under subparagraph (a)(14)(C) of Code Section 33-38-7 and Code Section 33-38-15, shall be delegated to a corporation, association, or other organization which performs or will perform functions similar to those of this association or its equivalent in two or more states. Such a corporation, association, or organization shall be reimbursed for any payments made on behalf of the association and shall be paid for its performance of any function of the association. A delegation under this Code section shall take effect only with the approval of both the board of directors and the Commissioner and may be made only to a

corporation, association, or organization which extends protection not substantially less favorable and effective than that provided for by this chapter.

GA CODE § 33-38-10

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

(1) The Commissioner shall:

(A) Upon request of the board of directors, provide the association with a statement of the premiums in the appropriate states for each member insurer; and

(B) When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time. Notice to the impaired insurer shall constitute notice to its shareholders, if any. The failure of the impaired insurer to comply promptly with such demand shall not excuse the association from the performance of its powers and duties under this chapter; and

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

Chapter 29. Individual Accident and Sickness Insurance

GA CODE § 33-29-1

(a) As used in this chapter, the term “accident and sickness policy” means any policy insuring against loss resulting from sickness or from bodily injury or death by accident, or both, or any contract to furnish ambulance service in the future.

(b) Nothing in this chapter shall apply to or affect:

(1) Any policy of workers' compensation insurance or any policy of workers' insurance or any policy of liability insurance with or without supplementary expense coverage on the policy;

(2) Any policy or contract of reinsurance;

(3) Any policy, the renewal of which is subject to continuation of employment with a specified employer, or any blanket or group policy of insurance, or any policy issued pursuant to the exercise of conversion privileges provided for in group insurance policies; or

(4) Life insurance, endowment or annuity contracts, or contracts supplemental thereto which contain only such provisions relating to accident and sickness insurance which provide additional benefits in case of death or dismemberment or loss of sight by accident, or which operate to safeguard such contracts against lapse or give a special surrender value or special benefit or an annuity in the event that the insured or annuitant becomes totally and permanently disabled as defined by the contract or supplemental contract.

GA CODE § 33-29-2

(a) No policy of accident and sickness insurance shall be delivered or issued for delivery in this state unless it meets the following requirements:

(1) The entire money and other considerations for the policy are expressed in such policy;

(2) The time at which the insurance takes effect and terminates is expressed in such policy;

(3) It purports to insure only one person, provided that a policy may insure, originally or by subsequent amendment upon the application of an adult member of a family who shall be deemed the policyholder, any two or more eligible members of that family, including husband, wife, dependent children, or any children, under a specified age which shall not exceed 19 years, and any other person dependent upon the policyholder; provided, further, that, if a policy purports to insure a dependent child of the policyholder, the child shall continue to be insured up to and including age 25 so long as the policy continues in effect, the child remains a dependent of the policyholder, and the child, in each calendar year since reaching the age specified in the policy for termination of benefits as a dependent of the policyholder, has been enrolled for five calendar months or more as a full-time student in a postsecondary institution of higher learning or, if not so enrolled, would have been eligible to be so enrolled and was prevented from being so enrolled due to illness or injury;

(4) The style, arrangement, and overall appearance of the policy gives no undue prominence to any portion of the text and every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in lightfaced type of a style in general use, the size of which shall be uniform and not less than ten-point with a lower case unspaced alphabet length not less than 120 point. The text shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions. When a policy is renewable only at the option of the insurer, such fact shall be made known in prominent lettering on the face of the policy;

(5) The exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in Code Sections 33-29-3 and 33-29-4, are printed, at the insurer's option, either with the benefit provisions to which they apply or under an appropriate caption such as “exceptions,” or “exceptions and reductions,” provided that, if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies;

(6) Each form, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page thereof;

(7) It contains no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks or short-rate table filed with the Commissioner;

(8) It contains no provision purporting to exclude or reduce coverage provided an otherwise insurable person solely for the reason that the person is eligible for or receiving medical assistance, as defined in Code Section 49-4-141. Any such provision appearing in an individual accident and sickness insurance policy shall be null and void; and

(9) It contains no provision relating to insurance with other insurers, provided that group conversion policies and major medical policies may contain provisions relating to other insurance benefits payable under group or blanket accident and sickness insurance policies.

(b) Individual major medical policies, including franchise and conversion policies, shall make available to each applicant for such coverage optional cash deductible amounts up to at least $5,000.00. No such policy shall contain any provision in which the length of the cash deductible accumulation period is not reasonable in relation to the amount of the cash deductibles. An insurer may offer higher optional deductibles to existing policyholders as a means of reducing the cost of such policies or to offset premium increases.

GA CODE § 33-29-3

(a) Each accident and sickness policy delivered or issued for delivery in this state shall contain the provisions specified in subsection (b) of this Code section in the words in which the same appear in subsection (b) of this Code section, except that the insurer may, at its option, substitute for one or more of such provisions corresponding provisions of different wording approved by the Commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. The provisions shall be preceded individually by the captions appearing in this Code section, or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the Commissioner may approve. If any such provision is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the Commissioner, shall omit from such policy any inapplicable provision or part of a provision and shall modify any inconsistent provision or part of a provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

(b)(1) ENTIRE CONTRACT; CHANGES.This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval is endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

(2) TIME LIMIT ON CERTAIN DEFENSES.

(A) After two years from the date of issue of this policy and in the absence of fraud, no misstatements made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability, as defined in the policy, commencing after the expiration of such two-year period. In order for the insurer to void the policy or to deny a claim for loss incurred or disability based upon an applicant's

fraudulent misstatement in an application, a copy of such application must be furnished to the policyholder or his or her beneficiary, and such fraudulent misstatement must have been in writing, must be material to the risk assumed by the insurer, and, in the case of a claim, must also relate to the specific type of loss or disability for which the claim is made.

(i) The policy provision in subparagraph (A) of this paragraph shall not be so construed as to affect any legal requirements for avoidance of a policy or denial of a claim during such initial two-year period, nor to limit the application of paragraphs (1) through (3) of subsection (b) of Code Section 33-29-4 in the event of misstatement with respect to age or occupation or other insurance. For purposes of this paragraph, fraud means the willful misrepresentation of a material fact.

(ii) A policy which the insurer has the right to continue in force subject to its terms by the timely payment of premium until at least age 60 or, in the case of a policy issued after age 54, for at least five years from its date of issue may contain in lieu of the provisions of subparagraph (A) of this paragraph the following provision, from which the clause in brackets may be omitted at the insurer's option, under the caption “incontestable”: In the absence of fraud and after this policy has been in force for a period of two years during the lifetime of the insured, excluding any period during which the insured is disabled, it shall become incontestable as to the statements contained in the application.

(B) In the absence of fraud, no claim for loss incurred or disability, as defined in the policy, commencing after two years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

(3) GRACE PERIOD.A grace period of _____ days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force. The insurer shall insert in the blank space a number not less than “seven” for weekly premium policies, “ten” for monthly premium policies and “30” for all other policies. A policy in which the insurer reserves the right to refuse renewal shall have at the beginning of the above provision the following language: “unless not less than 30 days prior to the premium due date the insurer has delivered to the insured or has mailed to his last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted.... ”

(4) REINSTATEMENT.

(A) If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of any premium by the insurer or by any agent duly authorized by the insurer to accept the premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that, if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall

cover only loss resulting from any accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after that date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

(B) The last sentence of subparagraph (A) of this paragraph may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums, until at least age 60, or, in the case of a policy issued after age 54, for at least five years from its date of issue.

(5) NOTICE OF CLAIM.

(A) Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at _____ (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

(B) In a policy providing a loss-of-time benefit which may be payable for at least two years, an insurer may at its option insert the following provision between the first and second sentences of subparagraph (A) of this paragraph:

“Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, he shall at least once in every six months after having given notice of claim give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of six months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six months preceding the date on which such notice is actually given.”

(6) CLAIM FORMS.The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If the forms are not furnished within ten working days after the giving of the notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

(7) PROOFS OF LOSS.Written proof of loss must be furnished to the insurer at its office, in case of a claim for loss for which this policy provides any periodic payment contingent upon continuing loss, within 90 days after the termination of the period for which the insurer is liable and, in case of claim for any other loss, within 90 days after

the date of such loss. Failure to furnish proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

(8) TIME OF PAYMENT OF CLAIMS.The policy shall include a provision incorporating and restating the substance of the provisions of subsections (b) and (c) of Code Section 33-24-59.5, relating to time limits for payment of claims for benefits under health benefit policies and sanctions for failure to pay timely. If a policy provides benefits for loss of time, such policy shall also provide that, subject to proof of such loss, all accrued benefits payable under the policy for loss of time will be paid not later than at the expiration of each period of 30 days during the continuance of the period for which the insurer is liable and any balance remaining unpaid at the termination of such period will be paid immediately upon receipt of such proof.

(9) PAYMENT OF CLAIMS.

(A) Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

(B) The following provisions, or either of them, may be included with the provisions of subparagraph (A) of this paragraph at the option of the insurer:

(i) If any indemnity of this policy shall be payable to the estate of the insured or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding $_____ (insert an amount which shall not exceed $1,000.00), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment;

(ii) Subject to any written direction of the insured in the application or otherwise, all or a portion of any indemnities provided by this policy on account of hospital, nursing, or medical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person.

(10) PHYSICAL EXAMINATIONS AND AUTOPSY.The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

(11) LEGAL ACTION.No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in

accordance with the requirements of this policy. No action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

(12) CHANGE OF BENEFICIARY.Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

(c) The first clause of paragraph (12) of subsection (b) of this Code section, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option.

(d) The provisions of this Code section shall also apply to individual accident and sickness insurance policies issued by a fraternal benefit society, a health care corporation, a health maintenance organization, or any other similar entity.

GA CODE § 33-29-3.1

(a) Every insurer authorized to issue individual accident and sickness insurance plans, policies, or contracts shall be required to make available, either as a part of or as an optional endorsement to all such policies providing major medical insurance coverage which are issued, delivered, issued for delivery, or renewed coverage for human heart transplants, including any charges for acquisition, transportation, or donation of a human heart when a human heart transplant is performed. Such coverage shall be at least as extensive and provide at least the same degree of coverage as that provided by the respective plan, policy, or contract for the treatment of other types of physical illnesses. Such an optional endorsement shall also provide that the coverage required to be made available pursuant to this Code section shall also cover the spouse and the dependents of the insured if the insured's spouse and dependents are covered under such benefit plan, policy, or contract.

(b) The optional endorsement required to be made available under subsection (a) of this Code section shall not contain any exclusions, reductions, or other limitations as to coverages, deductibles, or coinsurance provisions which apply to human heart transplants unless such provisions apply generally to other similar benefits provided or paid for under the accident and sickness insurance benefit plan, policy, or contract; provided, however, the optional endorsement may contain a waiting period for the coverage or a delayed eligibility date of not more than 12 months from the effective date of the endorsement.

(c) Nothing in this Code section shall be construed to prohibit an insurer, nonprofit corporation, health care plan, health maintenance organization, or other person issuing any similar individual accident and sickness insurance benefit plan, policy, or contract from issuing or continuing to issue an individual accident and sickness insurance benefit plan, policy, or contract which provides benefits greater than the minimum benefits required to be made available under this Code section or from issuing any such plans, policies, or contracts which provide benefits which are generally more favorable to the insured than those required to be made available under this Code section.

(d) Nothing in this Code section shall be construed to prohibit the inclusion of coverage for human heart transplants that differs from the coverage provided in the same insurance plan, policy, or contract for physical illnesses if the policyholder does not purchase the optional coverage made available pursuant to this Code section.

GA CODE § 33-29-3.2

(a) As used in this Code section, the term:

(1) “Female at risk” means a woman:

(A) Who has a personal history of breast cancer;

(B) Who has a personal history of biopsy proven benign breast disease;

(C) Whose grandmother, mother, sister, or daughter has had breast cancer; or

(D) Who has not given birth prior to age 30.

(2)(A) “Mammogram” means any low-dose radiologic screening procedure for the early detection of breast cancer provided to a woman and which utilizes equipment approved by the Department of Community Health dedicated specifically for mammography and includes a physician's interpretation of the results of the procedure or interpretation by a radiologist experienced in mammograms in accordance with guidelines established by the American College of Radiology.

(B) Reimbursement for a mammogram authorized under this Code section shall be made only if the facility in which the mammogram was performed meets accreditation standards established by the American College of Radiology or equivalent standards established by this state.

(C) Policies subject to this Code section shall contain coverage for mammograms made with at least the following frequency:

(i) Once as a base-line mammogram for any female who is at least 35 but less than 40 years of age;

(ii) Once every two years for any female who is at least 40 but less than 50 years of age;

(iii) Once every year for any female who is at least 50 years of age; and

(iv) When ordered by a physician for a female at risk.

(3) “Pap smear” or “Papanicolaou smear” means an examination, in accordance with standards established by the American College of Pathologists, of the tissues of the cervix of the uterus for the purpose of detecting cancer when performed upon the order of a physician, which examination may be made once a year or more often if ordered by a physician.

(4) “Policy” means any benefit plan, contract, or policy except a disability income policy, specified disease policy, or hospital indemnity policy.

(5) “Prostate-specific antigen test” means a measurement, in accordance with standards established by the American College of Pathologists, of a substance

produced by the epithelium to determine if there is any benign or malignant prostate tissue.

(b)(1) Every insurer authorized to issue an individual accident and sickness insurance policy in this state which includes coverage for any female shall include as part of or as a required endorsement to each such policy which is issued, delivered, issued for delivery, or renewed coverage for mammograms and Pap smears for the covered females which at least meets the minimum requirements of this Code section.

(2) Every insurer authorized to issue an individual accident and sickness insurance policy in this state which includes coverage for any male shall include as a part of or as a required endorsement to each such policy which is issued, delivered, issued for delivery, or renewed coverage for annual prostate-specific antigen tests for the covered males who are 45 years of age or older, or for covered males who are 40 years of age or older, if ordered by a physician.

(c) The coverage required under subsection (b) of this Code section may be subject to such exclusions, reductions, or other limitations as to coverages, deductibles, or coinsurance provisions as may be approved by the Commissioner.

(d) Nothing in this Code section shall be construed to prohibit the issuance of individual accident and sickness insurance policies which provide benefits greater than those required by subsection (b) of this Code section or more favorable to the insured than those required by subsection (b) of this Code section.

(e) The provisions of this Code section shall apply to individual accident and sickness insurance policies issued by a fraternal benefit society, a health care plan, a health maintenance organization, or any similar entity.

(f) Nothing contained in this Code section shall be deemed to prohibit the payment of different levels of benefits or from having differences in coinsurance percentages applicable to benefit levels for services provided by preferred and nonpreferred providers as otherwise authorized under the provisions of Article 2 of Chapter 30 of this title, relating to preferred provider arrangements.

(g) Every insurer subject to paragraph (1) of subsection (b) of this Code section shall provide notification to each female insured upon such female attaining the age of 40 of her coverage for mammograms and continuing annually thereafter, for as long as mammogram screening is recommended for such female insured based on her individual health status, as determined by her physician.

GA CODE § 33-29-3.3

(a) Every insurer authorized to issue individual accident and sickness insurance plans, policies, or contracts shall be required to make available, either as a part of or as an optional endorsement to all such policies providing major medical insurance coverage which are issued, delivered, issued for delivery, or renewed coverage for bone marrow transplants for the treatment of breast cancer and Hodgkin's disease. Such coverage shall be at least as extensive and provide at least the same degree of coverage as that provided by the respective plan, policy, or contract for the treatment of other types of physical illnesses. Such an optional endorsement shall also provide that the coverage

required to be made available pursuant to this Code section shall also cover the spouse and the dependents of the insured if the insured's spouse and dependents are covered under such benefit plan, policy, or contract.

(b) The optional endorsement required to be made available under subsection (a) of this Code section shall not contain any exclusions, reductions, or other limitations as to coverages, deductibles, or coinsurance provisions which apply to bone marrow transplants for the treatment of breast cancer and Hodgkin's disease unless such provisions apply generally to other similar benefits provided or paid for under the accident and sickness insurance benefit plan, policy, or contract.

(c) Nothing in this Code section shall be construed to prohibit an insurer, nonprofit corporation, health care plan, health maintenance organization, or other person issuing any similar individual accident and sickness insurance benefit plan, policy, or contract from issuing or continuing to issue an individual accident and sickness insurance benefit plan, policy, or contract which provides benefits greater than the minimum benefits required to be made available under this Code section or from issuing any such plans, policies, or contracts which provide benefits which are generally more favorable to the insured than those required to be made available under this Code section.

(d) Nothing in this Code section shall be construed to prohibit the inclusion of coverage for bone marrow transplants for the treatment of breast cancer and Hodgkin's disease that differs from the coverage provided in the same insurance plan, policy, or contract for physical illnesses if the policyholder does not purchase the optional coverage made available pursuant to this Code section.

(e) The provisions of this Code section shall apply to individual accident and sickness insurance policies issued by a fraternal benefit society, a health care plan, a health maintenance organization, or any similar entity.

GA CODE § 33-29-3.4

(a) As used in this Code section, the term:

(1) “Child wellness services” means the periodic review of a child's physical and emotional status conducted by a physician or conducted pursuant to a physician's supervision, but shall not include periodic dental examinations or other dental services. The review shall include a medical history, complete physical examination, developmental assessment, appropriate immunizations, anticipatory guidance for the parent or parents, and laboratory testing in keeping with prevailing medical standards.

(2) “Policy” means any health care plan, subscriber contract, or accident and sickness plan, contract, or policy by whatever name called other than a disability income policy, a long-term care insurance policy, a medicare supplement policy, a health insurance policy written as a part of workers' compensation equivalent coverage, a specified disease policy, a credit insurance policy, a hospital indemnity policy, a limited accident policy, or other type of limited accident and sickness policy.

(b) Every insurer authorized to issue an individual accident and sickness policy in this state shall include, either as a part of or as a required endorsement to each basic medical or hospital expense, major medical, or comprehensive medical expense policy

issued, delivered, issued for delivery, or renewed in this state basic coverage for child wellness services for an insured child from birth through the age of five years. Any such policy may provide that the child wellness services which are rendered during a periodic review shall only be covered to the extent that such services are provided by or under the supervision of a single physician during the course of one visit. The Commissioner shall define by regulation the basic coverage for child wellness services and may consider the current recommendations for preventive pediatric health care by the American Academy for Pediatrics and any other relevant data or information in the promulgation of such regulation.

(c) The coverage required under subsection (b) of this Code section may be subject to exclusions, reductions, or other limitations as to coverages or coinsurance provisions as may be approved by the Commissioner, but shall not be subject to deductibles.

(d) Nothing in this Code section shall be construed to prohibit the issuance of individual accident and sickness policies which provide benefits greater than those required by subsection (b) of this Code section or more favorable to the insured than those required by subsection (b) of this Code section.

(e) The provisions of this Code section shall apply to individual basic medical or hospital expense, major medical, or comprehensive medical expense insurance policies issued by a fraternal benefit society, a health care corporation, a health maintenance organization, or any similar entity.

(f) Nothing contained in this Code section shall be deemed to prohibit the payment of different levels of benefits or having differences in coinsurance percentages applicable to benefit levels for services provided by preferred and nonpreferred providers as otherwise authorized under the provisions of Article 2 of Chapter 30 of this title, relating to preferred provider arrangements.

GA CODE § 33-29-4

(a) No accident and sickness policy delivered or issued for delivery in this state shall contain provisions respecting the matters set forth in this Code section unless such provisions are in the words in which the same appear in subsection (b) of this Code section, except that the insurer may, at its option, use in lieu of any such provision a corresponding provision of different wording approved by the Commissioner which is not less favorable in any respect to the insured or the beneficiary. Any such provision contained in the policy shall be preceded individually by the appropriate caption appearing in this Code section or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the Commissioner may approve. If any such provision is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the Commissioner, shall omit from the policy any inapplicable provision or part of a provision and shall modify any inconsistent provision or part of a provision in such a manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

(b)(1) CHANGE OF OCCUPATION. If the insured is injured or contracts sickness after having changed his or her occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer shall pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes his or her occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, shall reduce the premium rate accordingly and shall return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer, prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation, with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued. If, however, such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in the state prior to the occurrence of the loss or prior to the date of proof of change in occupation.

(2) MISSTATEMENT OF AGE.If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.

(3) OTHER INSURANCE WITH THIS INSURER.

(A) If an accident or sickness or accident and sickness policy or policies previously issued by the insurer to the insured is in force concurrently herewith, making the aggregate indemnity for _____ (insert type of coverage or coverages) in excess of $ _____ (insert maximum limit of indemnity or indemnities), the excess insurance shall be void and all premiums paid for the excess shall be returned to the insured or to his or her estate;

or, in lieu thereof:

(B) Insurance effective at any one time on the insured under a like policy or policies with this insurer is limited to the one such policy elected by the insured, his or her beneficiary, or his or her estate, as the case may be, and the insurer will return all premiums paid for all other policies.

(4) RELATION OF EARNINGS TO INSURANCE.

(A) If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or his or her average monthly earnings for the period of two years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of the monthly earnings or the average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such

coverage upon the insured at the time such disability commences and for the return of that part of the premiums paid during such two years which exceeds the pro rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all the coverage upon the insured below the sum of $200.00 or the sum of the monthly benefits specified in the coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time.

(B) The policy provision of subparagraph (A) of this paragraph may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums until at least age 60 or, in the case of a policy issued after age 54, for at least five years from its date of issue. The insurer may, at its option, include in this provision a definition of “valid loss of time coverage,” approved as to form by the Commissioner, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, or to any other coverage the inclusion of which may be approved by the Commissioner or any combination of such coverages. In the absence of that definition the term shall not include any coverage provided for the insured pursuant to any compulsory benefit statute, including any workers' compensation or employer's liability statute, or benefits provided by union welfare plans or by employer or employee benefit organizations.

(5) UNPAID PREMIUM.Upon the payment of a claim under this policy, any premiums then due and unpaid or covered by any note or written order may be deducted therefrom.

(6) RETURN OF PREMIUM ON CANCELLATION.If the insured cancels this policy, the earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

(7) CONFORMITY WITH STATE STATUTES.Any provision of this policy which, on its effective date, is in conflict with the statutes of the state, District of Columbia, or territory in which the insured resides on such date is amended to conform to the minimum requirements of such statutes.

(8) ILLEGAL OCCUPATION.The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

(9) INTOXICANTS AND NARCOTICS.The insurer shall not be liable for any loss sustained or contracted in consequence of the insured being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

(10) CANCELLATION OF TRAVEL ACCIDENT POLICIES.With respect only to travel accident insurance policies, the following optional provisions may be inserted in the policy:

"The insurer reserves the right to cancel this policy under the provisions set forth in Code Section 33-24-44."

GA CODE § 33-29-5

The provisions which are the subject of Code Sections 33-29-3 and 33-29-4, or any corresponding provisions which are used in lieu thereof in accordance with such Code sections, shall be printed in consecutive order of the provisions in such Code sections or, at the option of the insurer, any such provisions may appear as a unit in any part of the policy, with other provisions to which they may be logically related, provided the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered, or issued.

GA CODE § 33-29-6

(a) The benefits on account of medical or surgical services provided by an individual policy of accident and sickness insurance may be limited by its terms to services performed by specifically defined professions, provided that in the absence of such definitions the term "physician" or "surgeon," as used in such policy, shall not be deemed limited solely to medical practitioners licensed under Chapter 34 of Title 43.

(b) When an individual policy of accident and sickness insurance, except policies providing special coverage for limited diseases, accident protection only, or dental policies, provides for hospital care, there may be included within the scope of coverage hospital care rendered on account of mental illnesses and hospital care rendered by any psychiatric hospital duly licensed by this state. If such coverage is not included in the policy, a statement that the policy does not cover mental illnesses shall be printed in the policy in boldface type or stamped on the face of the policy and printed or stamped on any identification card issued pursuant to any such policy.

(c) Any other laws to the contrary notwithstanding, whenever the term "physician" or "surgeon" is used in any policy of health or accident and sickness insurance issued in this state or in any contract for health care, services, or benefits existing under, and by virtue of, any laws of this state, said term shall include, within its meaning, medical practitioners licensed under and in accordance with Chapter 11 of Title 43, relating to dentists, in respect to any care, services, procedures, or benefits covered by said policy of insurance or health care contract which the said persons are licensed to perform, any provisions in any such policy of insurance or health care contract to the contrary notwithstanding. This subsection shall be applicable to all policies in this state, regardless of date of issue.

GA CODE § 33-29-7

(a) Subject to Code Section 33-29-21, each policy, covered by this chapter, except accident insurance only policies, in which the insurer reserves the right to refuse renewal on an individual basis, shall provide, in substance, in a provision of the policy entitled "renewability," that, subject to the right to terminate the policy upon nonpayment of premiums when due, the right to refuse renewal shall not be exercised before the

renewal date occurring on, or after and nearest, each anniversary or, in the case of lapse and reinstatement, at the renewal date occurring on, or after and nearest, each anniversary of the last reinstatement, and that any refusal or renewal shall be without prejudice to any claim originating while the policy is in force.

(b) The insurer shall not amend or endorse the policy prior to the anniversary date in a manner tending to restrict or lower the benefits, add exclusions, or increase the premium.

GA CODE § 33-29-8

(a) Except as provided in subsection (b) of this Code section, every insurer delivering or issuing for delivery in this state policies of accident and sickness insurance which are renewable at the option of the insurer or cancelable at the option of the insurer shall provide in said policies a provision as follows:

“If the company cancels or refuses to renew this policy except for nonpayment of premiums prior to age _____ (insert age which shall not be less than 60), it will refund 75 percent of the premiums paid in excess of the benefits received. The requirements of this provision shall not apply to cancellation or refusal to accept renewal premiums because of change in occupation of the insured to an occupation generally classified by the insurer as to all applicants as uninsurable.”

(b) This Code section shall not apply to and the provision prescribed in subsection (a) of this Code section need not be included in any major medical policy which provides that the insurer may cancel or refuse to renew the policy as of an anniversary date when also canceling or refusing to renew all policies with the same provisions and premium rate basis in the jurisdiction in which the insured resides, and then only if either or both of the following conditions are applicable:

(1) The insured is or could be covered by benefits, substantially similar in both kind and amount to those of the policy, in accordance with any federal or state governmental health insurance program; or

(2) The insurer is prevented by any law or any regulation or ruling of a governmental agency from applying to the policy a table of premium rates which the insurer certifies, based on its experience, is reasonable in relation to the benefits provided.

(c) For the purpose of this chapter, a major medical policy is any policy which provides benefits of at least 75 percent of necessary, reasonable, and customary charges for medical care, including hospitalization in semiprivate accommodations, with maximum lifetime benefit of at least $100,000.00, subject only to such exceptions, restrictions, limitations, and deductible as the Commissioner may deem reasonable.

GA CODE § 33-29-9

(a) No policy of accident or sickness insurance shall refer to its noncancelable nature without at the same time disclosing all options the insurer may have in regard to renewability; and the guaranteed renewable nature of any such policy shall not be referred to unless the reference at the same time discloses the qualifications on the

guarantee of renewability, including any age limits, any right to change premium rates by class, any aggregate provisions, and any other limitations on the right to renewal in a manner which shall not minimize or render obscure the qualifying conditions.

(b) An insurer operating in the major medical or comprehensive, guaranteed renewable business in this state shall permit an insured to change his or her major medical or comprehensive coverage, upon election at any renewal, to a comparable product offered by that insurer or a product offered by that insurer with more limited product benefits; to a product with higher deductibles; or to modify his or her existing coverage to elect any optional higher deductibles under that policy. If such product, benefit, or deductible change is elected by the insured during the 60 day required period after notice of renewal premium increase but before renewal date, such insured shall not be subject to any new preexisting conditions exclusion that did not apply to his or her original coverage.

(c) The Commissioner shall adopt such rules and regulations as he or she deems necessary for the administration of this Code section.

GA CODE § 33-29-10

(a) If any accident and sickness policy delivered or issued for delivery in this state contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective and, if the date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after such date, the coverage provided by the policy will continue in force until the end of the period for which premium has been accepted.

(b) In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective or would have ceased prior to the acceptance of the premium or premiums, then the liability of the insurer shall be limited to the refund, upon request, of all premiums paid for the period not covered by the policy.

GA CODE § 33-29-11

(a) Every individual accident and sickness policy or contract, except single premium nonrenewable policies or contracts, issued for delivery in this state by an insurer shall have printed on or attached to the policy or contract a notice stating in substance that the person to whom the policy or contract is issued shall be permitted to return the policy or contract within ten days of its delivery to said purchaser and to have the premium paid refunded if, after examination of the policy or contract, the purchaser is not satisfied with it for any reason.

(b) If the insured or purchaser, pursuant to such notice, returns the policy or contract to the insurer at its home or branch office, or to the agent through whom it was purchased, it shall be void from the beginning and the parties shall be in the same position as if no policy or contract had been issued. Without limiting any other method of returning a policy or contract under this Code section, it shall be prima-facie evidence of the fact and date of return of a policy or contract if the policy or contract is dispatched by

certified mail or statutory overnight delivery to the insurer or agent, as provided in this Code section, and a return receipt provided by the United States Postal Service or commercial delivery company is obtained.

GA CODE § 33-29-12

(a) Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this state, may contain any provision which is not less favorable to the insured or the beneficiary than those provisions contained in this chapter and which is prescribed or required by the law of the state under which the insurer is organized.

(b) Any policy of a domestic insurer may, when issued for delivery in any other state or country, contain any provision permitted or required by the laws of the other state or country.

GA CODE § 33-29-13

Every insurer shall furnish to any applicant for accident and sickness insurance in this state a written outline showing the major coverage of the policy applied for, the major exclusions of the policy applied for, the renewal provisions of the policy applied for, and a reference to the policy with respect to further provisions. The written outline shall be given to the applicant at the time of signing the application for the policy and the forms of the outlines shall be subject to the same requirements for filing and approval as are set forth for the filing and approval of policy forms as required in Code Sections 33-24-9 and 33-24-10.

GA CODE § 33-29-14

This chapter shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering the insured or from being entitled under such policy to any indemnities, benefits, and rights provided in the policy.

GA CODE § 33-29-15

(a) The proceeds or avails of all accident and sickness policies and of provisions providing benefits on account of the insured's disability which are supplemental to life insurance or annuity contracts, except credit accident and sickness policies and credit life policies, shall be exempt from all liability for any debt of the insured and from any debt of the beneficiary existing at the time the proceeds are made available for his or her use.

(b) The exemption of income benefits payable as the result of disability shall not exceed an average of $250.00 of such benefits per month of the period of disability.

GA CODE § 33-29-16

The requirements of this chapter may be complied with by the insurer by attaching to the policy such rider or endorsement as may be necessary for the purpose.

GA CODE § 33-29-17

(a) No policy provision which is not subject to this chapter shall make a policy, or any

portion thereof, less favorable in any respect to the insured or the beneficiary than the provisions thereof which are subject to this chapter.

(b) A policy delivered or issued for delivery to any person in this state in violation of this chapter shall be held valid but shall be construed as provided in this chapter. When any provision in a policy subject to this chapter is in conflict with any provision of this chapter, the rights, duties, and obligations of the insurer, the insured, and the beneficiary shall be governed by this chapter.

GA CODE § 33-29-18

(a) As used in this Code section, the term “employees” means the officers, managers, and employees and retired employees of the employer and the individual proprietor or partners if the employer is an individual proprietor or partnership.

(b) Accident and sickness insurance on a franchise plan is that form of accident and sickness insurance issued to:

(1) Two or more employees of any corporation, copartnership, or individual employer or any governmental corporation, agency, or department thereof; or

(2) Ten or more members, employees, or employees of members of any trade or professional association or of a labor union or of any other association having had an active existence for at least two years, where the association or union has a constitution or bylaws and is formed in good faith for purposes other than that of obtaining insurance; where the persons, with or without their dependents, are issued the same form of an individual policy varying only as to amounts and kinds of coverage applied for by the persons under an arrangement whereby the premiums on the policies may be paid to the insurer periodically by the employer, with or without payroll deductions, or by the association or union for its members, or by some designated person acting on behalf of such employee or association or union.

GA CODE § 33-29-19

(a) This Code section shall apply only to the filing of rate modifications for individual accident and sickness policies which provide for an optional loss ratio guarantee.

(b) As used in this Code section, the term:

(1) “Expected loss ratio” in an experience period means the ratio of: (A) the sum of expected claims in the experience period for each year of issue, based on the corresponding loss ratio standards as recited in accordance with paragraph (1) of subsection (d) of this Code section, to (B) the earned premium in the experience period.

(2) “Loss ratio” means the ratio of incurred claims to earned premium.

(c) Rate modification on individual accident and sickness policies which provide for an optional loss ratio guarantee must be filed with the Commissioner prior to implementation.

(d) At the time of filing new premium rates on any previously approved form for individual accident and sickness insurance policies which provide for an optional loss

ratio guarantee, the benefits provided by the policies shall be deemed reasonable as to the premium charged so long as the insurer complies with the terms of a loss ratio guarantee filed with the Commissioner. The loss ratio guarantee shall be in writing and shall include at least the following:

(1) A recitation of the loss ratio standards included in the original actuarial memorandum filed with the policy form at the time of the initial approval of the policy form. Such loss ratio standards must be given for each of the first ten years after issue;

(2) A guarantee that the actual loss ratios in this state for each experience period will meet or exceed the expected loss ratio in the experience period. If the annual earned premium volume in this state under a policy form is less than $1 million, the loss ratio guarantee shall be based on the actual loss ratio for the aggregate of states having less than $1 million of earned premium for the policy form. If such aggregate annual earned premium is less than $1 million, the experience period shall be extended until the end of the calendar year in which $1 million of earned premium is attained;

(3) A guarantee that the actual loss ratio results for each calendar year the rates are in effect shall be independently audited during the second quarter of the following year at the expense of the insurer. The audited results shall be reported to the Commissioner no later than the date for filing the applicable accident and sickness policy experience exhibit. The Commissioner may disapprove the audit for reasonable cause;

(4) A guarantee that affected policyholders in this state shall be issued a refund proportional to premiums paid in an amount such that when added to incurred claims will bring the actual loss ratio up to the expected loss ratio in the experience period. If aggregate loss ratios are used, the total amount refunded in this state shall equal the dollar amount necessary to achieve the loss ratio standards multiplied by the total premium earned in this state on the policy form and divided by the total premiums earned in all aggregated states on the policy form. The refund shall be made to all policyholders insured under the applicable policy form as of the last day of the applicable experience period and whose individual refund would equal $10.00 or more. The refund shall include interest at the maximum interest rate permitted by law in the valuation of whole life insurance issued on the last date of the applicable experience period calculated from the last day of the applicable experience period until the date of payment, which shall be during the third quarter of the following year; and

(5) A guarantee that refunds of less than $10.00 shall be aggregated by the insurer and paid to the Department of Insurance.

GA CODE § 33-29-20

(a) As used in this Code section, the term:

(1) “Functional deformity” means a deformity of the bone or joint structure of the maxilla or mandible such that the normal character and essential function of such bone structure is impeded.

(2) “Policy” means any major medical benefit plan, contract, or policy except a credit insurance policy, disability income policy, specified disease policy, hospital indemnity policy, limited accident policy, or other similarly limited accident and sickness policy.

(3) “Temporomandibular joint” means the connection of the mandible and the temporal bone through the articular disc surrounded by the joint capsule and associated ligaments and tendons.

(4) “Temporomandibular joint dysfunction” means congenital or developed anomalies of the temporomandibular joint.

(b) No policy may be issued or issued for delivery in this state which:

(1) Excludes medically necessary surgical or nonsurgical treatment for the correction of temporomandibular joint dysfunction by physicians or dentists professionally qualified by training and experience; or

(2) Excludes medically necessary surgery for the correction of functional deformities of the maxilla and mandible.

(c) The provisions of this Code section shall not cover cosmetic or elective orthodontic or periodontic care or general dental care.

(d)(1) The coverage under paragraph (1) of subsection (b) of this Code section may contain such types of exclusions, reductions, or other limitations as to coverages, deductibles, or coinsurance provisions which apply to other benefits under the accident and sickness insurance benefit plan, policy, or contract.

(2) Basic coverage for the nonsurgical treatment of temporomandibular joint dysfunction under paragraph (1) of subsection (b) of this Code section may be limited to history and examination; radiographs, which must be diagnostic for temporomandibular joint dysfunction; splint therapy with necessary adjustments, provided that removable appliances designed for orthodontic purposes would not be reimbursable under a major medical plan; and diagnostic or therapeutic masticatory muscle and temporomandibular joint injections.

(e) Except as provided in paragraph (1) of subsection (c) of Code Section 33-30-23, for policies limited only to dental coverage, nothing contained in this Code section shall be deemed to prohibit the payment of different levels of benefits or from having differences in coinsurance percentages applicable to benefit levels for services provided by preferred and nonpreferred providers as otherwise authorized under the provisions of Article 2 of Chapter 30 of this title, relating to preferred provider arrangements.

GA CODE § 33-29-21

Pursuant to the provisions of the federal Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, and subject to applicable rules and regulations as issued by the Centers for Medicare and Medicaid Services, all insurers which issue, issue for delivery, deliver, or renew existing individual policies, certificates, or contracts of accident and sickness insurance in this state shall, subject only to timely payment of premiums, renew or continue such coverage at the option of the insured. Such other exemptions and exclusions as are permitted by the federal Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, Section 2742 shall also apply to individual accident and sickness insurance and insurers in this state.

GA CODE § 33-29-21.1

Every policy which contains a provision for termination of coverage of a dependent upon the reaching of a certain age shall contain a provision to the effect that, upon the date of the dependent reaching the age at which coverage would terminate under the provisions of the policy, the dependent shall be entitled to have issued to him or her, without evidence of insurability, upon application made to the company within 45 days following the date the dependent reaches the age at which coverage would terminate and upon the payment of the appropriate premium, an individual or family policy of accident and sickness insurance then being issued by the insurer which provides coverage most nearly similar to the coverage contained in the policy which was terminated by reason of such dependent reaching a certain age or any similar individual or family policy then being issued by the insurer which contains lesser coverage. Any and all probationary or waiting periods set forth in such an individual or family policy shall be considered as being met to the extent coverage was in force under the prior policy.

GA CODE § 33-29-22

Notice of any premium increase shall be mailed or delivered to each holder of an individual accident and sickness insurance policy not less than 60 days prior to the effective date of such increase.

Chapter 43. Medicare Supplement Insurance

GA CODE § 33-43-1

As used in this chapter, the term:

(1) “Applicant” means:

(A) In the case of an individual medicare supplement policy or subscriber contract, the person who seeks to contract for insurance benefits; and

(B) In the case of a group medicare supplement policy, the proposed certificate holder.

(1.1) “Bankruptcy” means when a Medicare+Choice organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

(2) “Certificate” means any certificate delivered or issued for delivery in this state under a group medicare supplement policy.

(3) “Certificate form” means the form on which the certificate is delivered or issued for delivery by the issuer.

(3.1) “Continuous period of creditable coverage” means the period during which an individual was covered by creditable coverage if during the period of the coverage the individual had no breaks in coverage greater than 63 days.

(3.2)(A) “Creditable coverage” means, with respect to an individual, coverage of the individual provided under any of the following:

(i) A group health plan;

(ii) Health insurance coverage;

(iii) Part A or Part B of Title XVIII of the Social Security Act 1 (medicare);

(iv) Title XIX of the Social Security Act 2 (Medicaid), other than coverage consisting solely of benefits under Section 1928; 3

(v) Chapter 5 of Title 10 of the United States Code (CHAMPUS);

(vi) A medical care program of the Indian Health Service or of a tribal organization;

(vii) A state health benefits risk pool;

(viii) A health plan offered under Chapter 89 of Title 5 of the United States Code (Federal Employees Health Benefits Program);

(ix) A public health plan as defined in federal regulation; or

(x) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. Section 2504(e)).

(B) Creditable coverage shall not include one or more, or any combination of, the following:

(i) Coverage only for accident or disability income insurance, or any combination thereof;

(ii) Coverage issued as a supplement to liability insurance;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Workers' compensation or similar insurance;

(v) Automobile medical payment insurance;

(vi) Credit only insurance;

(vii) Coverage for on-site medical clinics; or

(viii) Other similar insurance coverage, specified in the Code of Federal Regulations as of July 1, 2000, under which benefits for medical care are secondary or incidental to other insurance benefits.

(C) Creditable coverage shall not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:

(i) Limited scope dental or vision benefits;

(ii) Benefits for long-term care, nursing home care, home health care, community based care, or any combination thereof; or

(iii) Such other similar, limited benefits as are specified in the Code of Federal Regulations as of July 1, 2000.

(D) Creditable coverage shall not include the following benefits if offered as independent, noncoordinated benefits:

(i) Coverage only for a specified disease or illness; or

(ii) Hospital indemnity or other fixed indemnity insurance.

(E) Creditable coverage shall not include the following if offered as a separate policy, certificate, or contract of insurance:

(i) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act; 4

(ii) Coverage supplemental to the coverage provided under Chapter 55 of Title 10 of the United States Code; or

(iii) Similar supplemental coverage provided to coverage under a group health plan.

(3.3) “Employee welfare benefit plan” means a plan, fund, or program of employee benefits as defined in 29 U.S.C. Section 1002 (Employee Retirement Income Security Act).

(3.4) “Insolvency” means when an issuer, licensed to transact the business of insurance in this state, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.

(4) “Issuer” includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this state medicare supplement policies or certificates.

(5) “Medicare” means the “Health Insurance for the Aged Act,” Title XVIII of the Social Security Act Amendments of 1965, as then constituted or later amended.

(6) “Medicare supplement policy” means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395, et seq.) or an issued policy under a demonstration project specified in 42 U.S.C. Section 1395ss(g) (1), which is advertised, marketed, or designed primarily as a supplement to reimbursements under medicare for the hospital, medical, or surgical expenses of persons eligible for medicare.

(6.1) “Medicare+Choice plan” means a plan of coverage for health benefits under medicare Part C as defined in P.L. 105-33, and includes:

(A) Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider sponsored organizations, and preferred provider organization plans;

(B) Medical savings account plans coupled with a contribution into a Medicare+Choice medical savings account; and

(C) Medicare+Choice private fee-for-service plans.

(7) “Policy form” means the form on which the policy is delivered or issued for delivery by the issuer.

(8) “Secretary” means the secretary of the United States Department of Health and Human Services.

1 42 U.S.C.A. § 1395 et seq.

2 42 U.S.C.A. § 1396 et seq.

3 42 U.S.C.A. § 1396s.

4 42 U.S.C.A. § 1395ss.

GA CODE § 33-43-2

(a) Except as otherwise specifically provided, this chapter shall apply to:

(1) All medicare supplement policies delivered or issued for delivery in this state; and

(2) All certificates issued under group medicare supplement policies, which certificates have been delivered or issued for delivery in this state.

(b) This chapter shall not apply to a policy of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations or a combination thereof, for employees or former employees or a combination thereof, or for members or former members or a combination thereof of the labor organizations.

(c) Except as provided under subsection (d) of Code Section 33-43-5, the provisions of this chapter shall not be construed to prohibit or apply to insurance policies or health care benefit plans, including group conversion policies, provided to medicare eligible persons, which policies are not marketed or held to be medicare supplement policies or benefit plans.

GA CODE § 33-43-3

(a) No medicare supplement insurance policy or certificate in force in this state shall contain benefits which duplicate benefits provided by medicare.

(b) Notwithstanding any other provision of Georgia law, a medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

(c) The Commissioner shall adopt reasonable regulations to establish specific standards for policy provisions of medicare supplement policies and certificates. Such standards shall be in addition to and in accordance with applicable laws of this state. No requirement of this title relating to minimum required policy benefits, other than the minimum standards contained in this chapter, shall apply to medicare supplement policies and certificates. The standards shall cover, but shall not be limited to:

(1) Terms of renewability;

(2) Initial and subsequent conditions of eligibility;

(3) Nonduplication of coverage;

(4) Probationary periods;

(5) Benefit limitations, exceptions, and reductions;

(6) Elimination periods;

(7) Requirements for replacement;

(8) Recurrent conditions; and

(9) Definitions of terms.

(d) The Commissioner shall adopt reasonable regulations to establish minimum standards for benefits, claims payment, marketing practices, compensation arrangements, and reporting practices for medicare supplement policies and certificates.

(e) The Commissioner may adopt from time to time such reasonable regulations as are necessary to conform medicare supplement policies and certificates to the requirements of federal law and regulations promulgated thereunder, including, but not limited to:

(1) Requiring refunds or credits if the policies or certificates do not meet loss ratio requirements;

(2) Establishing a uniform methodology for calculating and reporting loss ratios;

(3) Assuring public access to policies, premiums, and loss ratio information of issuers of medicare supplement insurance;

(4) Establishing a process for approving or disapproving policy forms, certificate forms, and proposed premium increases;

(5) Establishing a policy for holding public hearings prior to approval of premium increases; and

(6) Establishing standards for medicare select policies and certificates.

(f) The Commissioner may adopt reasonable regulations that specify prohibited policy provisions not otherwise specifically authorized by statute which, in the opinion of the Commissioner, are unjust, unfair, or unfairly discriminatory to any person insured or proposed to be insured under a medicare supplement policy or certificate.

(g) Insurers offering medicare supplement policies in this state to persons 65 years of age or older shall also offer medicare supplement policies to persons in this state who are eligible for and enrolled in medicare by reason of disability or end-stage renal disease. Except as otherwise provided in this Code section, all benefits, protections, policies, and procedures that apply to persons 65 years of age or older shall also apply to persons who are eligible for and enrolled in medicare by reason of disability or end-stage renal disease.

(h) Persons may enroll in a medicare supplement policy at any time authorized or required by the federal government or within six months of:

(1) Enrolling in medicare Part B for an individual who is under 65 years of age and is eligible for medicare because of disability or end-stage renal disease, whichever is later;

(2) Receiving notice that such person has been retroactively enrolled in medicare Part B due to a retroactive eligibility decision made by the Social Security Administration; or

(3) Experiencing a qualifying event identified in regulations adopted pursuant to subsection (c) of this Code section.

(i) No policy or certificate issued pursuant to this chapter shall prohibit payment made by third parties on behalf of individual applicants or individuals within a group applicant so long as:

(1) The third party is an immediate family member of a person lawfully exercising an in-force power of attorney or legal guardianship; or

(2) The third party is a nonprofit, charitable organization that:

(A) Is the named requestor of an advisory opinion issued by the United States Department of Health and Human Services (HHS) Office of Inspector General under the requirements of 42 C.F.R. Part 1008; and

(B) Provides, upon request by the medicare supplement issuer, the specific advisory opinion relied upon by the third party to make such payment and a written certification that the advisory opinion is in full force and effect and has not been rescinded, modified, or terminated by the United States Department of Health and Human Services (HHS) Office of Inspector General.

(j) Premiums for medicare supplemental insurance policies may differ between persons who qualify for medicare who are 65 years of age or older and those who qualify for medicare who are younger than 65 years of age; provided, however, that such differences in premiums shall not be excessive, inadequate, or unfairly discriminatory and shall be based on sound actuarial principles and reasonable in relation to the benefits provided.

GA CODE § 33-43-4

Medicare supplement policies shall return to policyholders benefits which are reasonable in relation to the premium charged. The Commissioner shall issue reasonable regulations to establish minimum standards for loss ratios of medicare supplement policies on the basis of incurred claims experience, or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis, and earned premiums in accordance with accepted actuarial principles and practices.

GA CODE § 33-43-5

(a) In order to provide for full and fair disclosure in the sale of medicare supplement policies, no medicare supplement policy or certificate shall be delivered in this state unless an outline of coverage is delivered to the applicant at the time application is made.

(b) The Commissioner shall prescribe the format and content of the outline of coverage required by subsection (a) of this Code section. For purposes of this Code section, “format” means style, arrangements, and overall appearance, including such items as

the size, color, and prominence of type and arrangement of text and captions. Such outline of coverage shall include:

(1) A description of the principal benefits and coverage provided in the policy;

(2) A statement of the exceptions, reductions, and limitations contained in the policy;

(3) A statement of the renewal provisions, including any reservation by the issuer of a right to change premiums; and

(4) A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions.

(c) The Commissioner may prescribe by regulation a standard form and the contents of an informational brochure for persons eligible for medicare, which is intended to improve the buyer's ability to select the most appropriate coverage and improve the buyer's understanding of medicare. Except in the case of direct response insurance policies, the Commissioner may require by regulation that the informational brochure be provided to any prospective insureds eligible for medicare concurrently with delivery of the outline of coverage. With respect to direct response insurance policies, the Commissioner may require by regulation that the prescribed brochure be provided upon request to any prospective insureds eligible for medicare, but in no event shall the brochure be provided later than the time of policy delivery.

(d) The Commissioner may prescribe by regulation for captions or notice requirements, determined to be in the public interest and designed to inform prospective insureds that particular insurance coverages are not medicare supplement coverages for all accident and sickness insurance policies sold to persons eligible for medicare, other than:

(1) Medicare supplement policies; or

(2) Disability income policies.

(e) The Commissioner may adopt reasonable regulations to govern the full and fair disclosure of the information in connection with the replacement of accident and sickness policies, subscriber contracts, or certificates by persons eligible for medicare.

GA CODE § 33-43-6

Medicare supplement policies or certificates shall have a notice prominently printed on the first page of the policy or certificate stating in substance that the applicant shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Any refund made pursuant to this Code section shall be paid directly to the applicant by the issuer in a timely manner.

GA CODE § 33-43-7

Every issuer of medicare supplement insurance in this state shall provide a copy of any medicare supplement advertisement intended for use in this state whether through written, radio, or television medium to the Commissioner for review and approval by the Commissioner.

GA CODE § 33-43-8

Regulations adopted pursuant to this chapter shall be subject to the provisions of this chapter and Code Section 33-2-9.

Chapter 42. Long-Term Care Insurance

GA CODE § 33-42-1
This chapter may be known and cited as the “Long-term Care Insurance Act.”

GA CODE § 33-42-2
The purpose of this chapter is to promote the public interest, to promote the availability of long-term care insurance policies, to protect applicants for long-term care insurance as defined from unfair or deceptive sales or enrollment practices, to establish standards for long-term care insurance, to facilitate public understanding and comparison of long-term care insurance policies, and to facilitate flexibility and innovation in the development of long-term care insurance coverage.

GA CODE § 33-42-3
The requirements of this chapter shall apply to long-term care insurance policies issued, delivered, or issued for delivery in this state. This chapter is not intended to supersede the obligations of entities subject to this chapter to comply with the substance of other applicable provisions of this title insofar as they do not conflict with this chapter, except that laws and regulations designed and intended to apply to medicare supplement insurance policies shall not be applied to long-term care insurance. A policy which is not advertised, marketed, or offered as long-term care insurance need not meet the requirements of this chapter.

GA CODE § 33-42-4
As used in this chapter, the term:

(1) “Applicant” means:

(A) In the case of an individual long-term care insurance policy, the person who seeks to contract for such benefits; and

(B) In the case of a group long-term care insurance policy, the proposed certificate holder.

(2) “Certificate” means any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this state.

(3) “Group long-term care insurance” means a long-term care insurance policy which is issued, delivered, or issued for delivery in this state and issued to:

(A) Any eligible group as defined in Code Section 33-30-1; or

(B) A group other than as described in Code Section 33-30-1, subject to a finding by the Commissioner that:

(i) The issuance of the group policy is not contrary to the best interest of the public;

(ii) The issuance of the group policy would result in economies of acquisition or administration; and

(iii) The benefits are reasonable in relation to the premiums charged.

(4) “Long-term care insurance” means any accident and sickness insurance policy or rider advertised, marketed, offered, or designed primarily to provide coverage for not less than 12 consecutive benefit months or which provides coverage for recurring confinements separated by a period not to exceed six months with a minimum aggregate period of one year for each covered person on an expense incurred, indemnity, prepaid, or other basis, for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital. Such term includes group and individual accident and sickness policies or riders whether issued by insurers, fraternal benefit societies, health care plans, health maintenance organizations, or any other similar organizations. Long-term care insurance shall not include any accident and sickness insurance policy which is offered primarily to provide basic medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, catastrophic coverage, comprehensive coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. Long-term care insurance may be provided through an individual or group life insurance policy by attachment of a long-term care rider or by the automatic inclusion of a long-term care provision which, notwithstanding Code Section 33-42-3, must meet the requirements of this chapter and regulations promulgated by the Commissioner. Any such long-term care riders or policy provisions shall not be exempt from filing requirements and must be filed with the department for approval before being used in this state.

(5) “Policy” means any policy, contract, or subscriber agreement or any rider or endorsement attached thereto, issued, delivered, issued for delivery, or renewed in this state by an insurer, fraternal benefit society, health care plan, health maintenance organization, or any other similar organization. Such term shall also include a Georgia Qualified Long-term Care Partnership Program approved policy, as defined in paragraph (4) of Code Section 49-4-161, meeting the requirements of the Georgia Qualified Long-term Care Partnership Program as enacted in subsection (a) of Code Section 49-4-162.

GA CODE § 33-42-5

No group long-term care insurance coverage may be offered to a resident of this state under a group policy issued in another state to a group described in subparagraph (B) of paragraph (3) of Code Section 33-42-4 unless this state or another state having statutory and regulatory long-term care insurance requirements substantially similar to those adopted in this state has made a determination that such requirements have been met.

GA CODE § 33-42-6

(a) The Commissioner may adopt regulations that include standards for full and fair disclosure setting forth the manner, content, and required disclosures for the sale of long-term care insurance policies and for any applicable terms of renewability, initial and

subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents, preexisting conditions, termination of insurance, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, and definition of terms.

(b) No long-term care insurance policy may:

(1) Be canceled, nonrenewed, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder;

(2) Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new policy or other form of policy within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or

(3) Provide coverage for skilled nursing care only or provide coverage for other levels of care which is unreasonably lower than the coverage provided for skilled nursing care in a facility.

(c)(1) No long-term care insurance policy or certificate shall use a definition of “preexisting condition” which is more restrictive than the following: Preexisting condition means the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care, or treatment, or a condition for which medical advice or treatment was recommended by or received from a provider of health care services, within six months preceding the effective date of coverage of an insured person.

(2) No long-term care insurance policy may exclude coverage for a loss or confinement which is the result of a preexisting condition unless such loss or confinement begins within six months following the effective date of coverage of an insured person.

(3) The Commissioner may extend the limitation periods set forth in paragraphs (1) and (2) of this subsection as to specific age group categories or specific policy forms upon findings that the extension is in the best interest of the public.

(4) The definition of “preexisting condition” shall not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period provided in paragraph (2) of this subsection expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in paragraph (2) of this subsection.

(d)(1) No long-term care insurance policy which provides benefits only following institutionalization shall condition such benefits upon admission to a facility for the same or related condition within a period of less than 30 days after discharge from the institution.

(2) Notwithstanding paragraph (1) of this subsection, no long-term care insurance policy which conditions the eligibility of benefits on prior hospitalization may be delivered or issued for delivery in this state unless the insurer or other entity offering that policy also offers a long-term care insurance policy which does not condition eligibility of benefits on such a requirement.

(e) The Commissioner may adopt regulations establishing loss ratio standards for long-term care insurance policies, provided that a specific reference to long-term care insurance policies is contained in the regulation.

(f) Individual long-term care insurance policyholders shall have the right to return the policy within 30 days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason. Individual long-term care insurance policies shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the policyholder shall have the right to return the policy within 30 days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason. Long-term care insurance policies or certificates issued pursuant to a direct response solicitation shall have a notice prominently printed on the first page or attached thereto stating in substance that the insured person shall have the right to return the policy within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

(g) An outline of coverage shall be delivered to an applicant for an individual long-term care insurance policy at the time of application for an individual policy. In the case of direct response solicitations, the insurer shall deliver the outline of coverage upon the applicant's request, but regardless of request shall make such delivery no later than at the time of policy delivery. Such outline of coverage shall comply with the applicable provisions of Code Section 33-29-13.

(h) A certificate issued pursuant to a group long-term care insurance policy, which policy is issued, delivered, issued for delivery, or renewed in this state, shall include:

(1) A description of the principal benefits and coverage provided in the policy;

(2) A statement of the principal exclusions, reductions, and limitations contained in the policy;

(3) A statement that the group master policy determines governing contractual provisions; and

(4) Such other provisions as the Commissioner may reasonably require.

(i) No policy may be advertised, marketed, or offered as long-term care insurance unless it complies with the provisions of this chapter.