

R590. Insurance, Administration.

R590-190. Unfair Property, Liability and Title Claims Settlement Practices Rule.

R590-190-1. Authority.

This rule is promulgated pursuant to Subsections 31A-2-201(1) and 31A-2-201(3)(a) in which the commissioner is empowered to administer and enforce this title and to make rules to implement the provisions of this title. Further authority to provide for timely payment of claims is provided by Subsection 31A-26-301(1). Matters relating to proof and notice of loss are promulgated pursuant to Section 31A-26-301 and Subsection 31A-21-312(5). Authority to promulgate rules defining unfair claims settlement practices or acts is provided in Subsection 31A-26-303(4). The authority to require a timely response to the Insurance Department is provided in Section 31A-2-202(4).

R590-190-2. Purpose.

This rule sets forth minimum standards for the investigation and disposition of property, liability, and title claims arising under contracts or certificates issued to residents of the State of Utah. It is not intended to cover bail bonds. These standards include fair and rapid settlement of claims, protection for claimants under insurance policies from unfair claims adjustment practices and promotion of professional competence of those engaged in claim adjusting. This rule defines procedures and practices which constitute unfair claim practices. This rule is regulatory in nature and is not intended to create any private right of action.

R590-190-3. Definitions.

For the purpose of this rule the commissioner adopts the definitions as set forth in 31A-1-301, and the following:

(1) "Claim file" means any record either in its original form or as recorded by any process which can accurately and reliably reproduce the original material regarding the claim, its investigation, adjustment and settlement.

(2) "Claimant" means either a first party claimant, a third party claimant, or both and includes such claimant's designated legal representative and includes a member of the claimant's immediate family designated by the claimant.

(3) "Claim representative" means any individual, corporation; association, organization, partnership, or other legal entity authorized to represent an insurer with respect to a claim, whether or not licensed within the State of Utah to do so.

(4) "Days" means calendar days.

(5) "Documentation" includes, but is not limited to, any pertinent communications, transactions, notes, work papers, claim

forms, bills, and explanation of benefits forms relative to the claim.

(6) "First party claimant" means an individual, corporation, association, partnership or other legal entity asserting a right to a benefit or a payment under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by such policy or contract and includes such claimant's designated legal representative and includes a member of the claimant's immediate family designated by the claimant.

(7) "General business practice" means a pattern of conduct.

(8) "Investigation" means all activities of an insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy or insurance contract.

(9) "Notice of claim or loss" means any notification, whether in writing or other means acceptable under the terms of an insurance policy or insurance contract, to an insurer or its agent, by a claimant, which reasonably apprizes the insurer of the facts pertinent to a claim.

(10) "Proof of loss" shall mean reasonable documentation by the insured in accordance with policy provisions and insurer practices as to the facts of the loss and the amount of the claim.

(11) "Specific disclosure" shall mean notice to the insured by means of policy provisions in boldface type or a separate written notice mailed or delivered to the insured.

(12) "Third party claimant" means any person asserting a claim against any person under a policy or certificate of an insurer.

R590-190-4. File and Record Documentation.

Each insurer's claim files for policies or certificates are subject to examination by the commissioner of insurance or by the commissioner's duly appointed designees. To aid in such examination:

(1) the insurer shall maintain claim data that is accessible and retrievable for examination; and

(2) detailed documentation shall be contained in each claim file to permit reconstruction of the insurer's activities relative to the claim.

R590-190-5. Misrepresentation of Policy Provisions.

(1) The insurer and its representatives shall fully disclose to first party claimants all pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented, including loss of use and household services.

(2) The insurer is prohibited from denying a claim based

upon a first party claimant's failure to exhibit the property unless there is documentation of a breach of the policy provision in the claim file.

R590-190-6. Failure to Acknowledge Pertinent Communications.

Within 15-days every insurer shall:

(1) upon receiving notification of a claim, acknowledge the receipt of such notice unless payment is made within such period of time, or unless the insurer has a reason acceptable to the Insurance Department as to why such acknowledgment cannot be made within the time specified. Notice given to an agent of an insurer is notice to the insurer;

(2) provide a substantive response to a claimant whenever a response has been requested; and

(3) upon receiving notification of a claim, provide all necessary claim forms, instructions, and reasonable assistance so that first party claimants can comply with the policy conditions and the insurer's reasonable requirements.

R590-190-7. Notice of Claim or Loss.

(1) Notice of Claim or Loss to an insurer, if required, shall be considered timely if made according to the terms of the policy, subject to the definitions and provisions of this rule, and the provisions of Section 31A-21-312.

(2) Notice of Claim or Loss may be given by an insured to any appointed agent, authorized adjuster, or other authorized claim representative of an insurer unless the insurer clearly directs otherwise by means of Specific Disclosure as defined herein.

(3) The general practice of the insurer when accepting a notice of loss or notice of claim shall be consistent for all policyholders in accordance with the terms of the policy.

R590-190-8. Proof of Loss.

Proof of loss to an insurer, if required, shall be considered timely if made according to the terms of the policy, subject to the definitions and provisions of this rule and the requirements of Section 31A-21-312.

R590-190-9. Unfair Methods, Deceptive Acts and Practices Defined.

The commissioner, pursuant to Section 31A-26-303(4), hereby finds the following acts, or the failure to perform required acts, to be misleading, deceptive, unfairly discriminatory or overreaching in the settlement of claims:

(1) denying or threatening the denial of the payment of claims or rescinding, canceling or threatening the rescission or cancellation of coverage under a policy for any reason which is

not clearly described in the policy as a reason for such denial, cancellation or rescission;

(2) failing to provide the insured or beneficiary with a written explanation of the evidence of any investigation or file materials giving rise to the denial of a claim based on misrepresentation or fraud on an insurance application, when such misrepresentation is the basis for the denial;

(3) compensation by an insurer of its employees, agents or contractors of any amounts which are based on savings to the insurer as a result of denying the payment of claims;

(4) failing to deliver a copy of the insurer's guidelines, which could include the department's statutes, rules and bulletins, for prompt investigation of claims to the Insurance Department when requested to do so;

(5) refusing to pay claims without conducting a reasonable investigation;

(6) offering first party claimants substantially less than the reasonable value of the claim. Such value may be established by one or more independent sources;

(7) making claim payments to insureds or beneficiaries not accompanied by a statement or explanation of benefits setting forth the coverage under which the payments are being made and how the payment amount was calculated;

(8) failing to pay claims within 30-days of properly executed proof of loss when liability is reasonably clear under one coverage in order to influence settlements under other portions of the insurance policy coverage or under other policies of insurance;

(9) refusing payment of a claim solely on the basis of an insured's request to do so unless:

(a) the insured claims sovereign, eleemosynary, diplomatic, military service, or other immunity from suit or liability with respect to such claim; or

(b) the insured is granted the right under the policy of insurance to consent to settlement of claims.

(10) advising a claimant not to obtain the services of an attorney or suggesting the claimant will receive less money if an attorney is used to pursue or advise on the merits of a claim;

(11) misleading a claimant as to the applicable statute of limitations;

(12) requiring an insured to sign a release that extends beyond the occurrence or cause of action that gave rise to the claims payment;

(13) deducting from a loss or claim payment made under one policy those premiums owed by the insured on another policy, unless the insured consents;

(14) failing to settle a first party claim on the basis that

responsibility for payment of the claim should be assumed by others, except as may otherwise be provided by policy provisions;

(15) issuing checks or drafts in partial settlement of a loss or a claim under a specified coverage when such check or draft contains language which purports to release the insurer or its insured from total liability;

(16) refusing to provide a written basis for the denial of a claim upon demand of the insured;

(17) denying a claim for medical treatment after preauthorization has been given, except in cases where the insurer obtains and provides to the claimant documentation of the pre-existence of the condition for which the preauthorization has been given or if the claimant is not eligible for coverage;

(18) refusing to pay reasonably incurred expenses to an insured when such expenses resulted from a delay, as prohibited by these rules, in claims settlement or claims payment;

(19) when an automobile insurer represents both a tortfeasor and a claimant:

(a) failing to advise a claimant under any coverage that the same insurance company represents both the tortfeasor and the claimant as soon as such information becomes known to the insurer; and

(b) allocating medical payments to the tortfeasor's liability coverage before exhausting a claimant's personal injury protection coverage.

(20) failing to pay interest at the legal rate, as provided in Title 15, Utah Code, upon amounts that are overdue under these rules. This does not apply to insurers who fail to pay Personal Injury Protection expenses when due. These expenses shall bear interest as provided in 31A-22-309(5)(c).

R590-190-10. Minimum Standards for Prompt, Fair and Equitable Settlements.

(1) The insurer shall provide to the claimant a statement of the time and manner in which any claim must be made and the type of proof of loss required by the insurer.

(2) Within 30-days after receipt by the insurer of a properly executed proof of loss, the insurer shall complete its investigation of the claim and the first party claimant shall be advised of the acceptance or denial of the claim by the insurer unless the investigation cannot be reasonably completed within that time. If the insurer needs more time to determine whether a first party claim should be accepted or denied, it shall so notify the first party claimant within 30-days after receipt of the proofs of loss, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, within 45-days after sending the initial notification and within every 45-

days thereafter, send to the first party claimant a letter setting forth the reasons additional time is needed for the investigation, unless the first party claimant is represented by legal counsel or public adjuster. Any basis for the denial of a claim shall be noted in the insurers claim file and must be communicated promptly and in writing to the first party claimant. Insurers are prohibited from denying a claim on the grounds of a specific provision, condition, or exclusion unless reference to such provision, condition or exclusion is included in the denial.

(3) Unless otherwise provided by law, an insurer shall promptly pay every valid insurance claim. A claim shall be overdue if not paid within 30-days after the insurer is furnished written proof of the fact of a covered loss and of the amount of the loss. Payment shall mean actual delivery or mailing of the amount owed. If such written proof is not furnished to the insurer as to the entire claim, any partial amount supported by written proof or investigation is overdue if not paid within 30-days. Payments are not deemed overdue when the insurer has reasonable evidence to establish that the insurer is not responsible for the payment, notwithstanding that written proof has been furnished to the insurer.

(4) If negotiations are continuing for settlement of a claim with a claimant, who is not represented by legal counsel or public adjuster, notice of expiration of the statute of limitation or contract time limit shall be given to the claimant at least 60 days before the date on which such time limit may expire.

(5) Insurers are prohibited from making statements which indicate that the rights of a third party claimant may be impaired if a form or release is not completed within a given period of time unless the statement is given for the purpose of notifying the third party claimant of the provision of a statute of limitations.

(6) Upon receipt of an inquiry from the insurance department regarding a claim, every licensee shall furnish a substantive response to the insurance department within the time period specified in the inquiry.

R590-190-11. Standards for Prompt, Fair and Equitable Settlements Applicable to Automobile Insurance.

(1) When the insurance policy provides for the adjustments and settlement of automobile total losses for first party claimants on the basis of actual cash value or replacement with another of like kind and quality, one of the following methods must apply:

(a) the insurer may elect to offer a replacement automobile which is a specific comparable automobile available to the insured, with all applicable taxes, license fees and other fees

incident to transfer of evidence of ownership of the automobile paid, at no cost other than any deductible provided in the policy. The offer and any rejection thereof must be documented in the claim file;

(b) the insurer may elect a cash settlement based upon the actual cost, less any deductible provided in the policy, to purchase a comparable automobile including all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of a comparable automobile. Such cost may be determined by using:

(i) the cost of two or more comparable automobiles in the local market area when a comparable automobile is available or was available within the last 90-days to consumers in the local market area;

(ii) the cost of two or more comparable automobiles in areas proximate to the local market area, including the closest major metropolitan areas within or without the state, that are available or were available within the last 90-days to consumers when comparable automobiles are not available in the local market area pursuant to Subsection R590-190-11.(1)(b)(i);

(iii) one of two or more quotations obtained by the insurer from two or more qualified dealers located within the local market area when a comparable automobile is not available in the local market area; or

(iv) any source of determining statistically valid fair market values that meet all of the following criteria:

(A) the source shall give primary consideration to the values of vehicles in the local market area and may consider data on vehicles outside the area;

(B) the source's database shall produce values for at least 85% of the makes and models for the last 15 model years, taking into account the values of all major options for such vehicles; and

(C) the source shall produce fair market values based on current data available from the area surrounding the location where the insured vehicle was principally garaged or a necessary expansion of parameters, such as time and area, to assure statistical validity.

(v) if the insurer is notified within 30-days of the receipt of the claim draft that the first party claimant cannot purchase a comparable vehicle for such market value, the company shall reopen its claim file and the following procedure(s) shall apply:

(A) the company may locate a comparable vehicle by the same manufacturer, same year, similar body style and similar options and price range for the insured for the market value determined by the company at the time of settlement. Any such vehicle must be available through licensed dealers or private sellers;

(B) the company shall either pay the difference between market value before applicable deductions and the cost of the comparable vehicle of like kind and quality which the insured has located, or negotiate and effect the purchase of this vehicle for the insured;

(C) the company may elect to offer a replacement in accordance with the provisions set forth in Subsection R590-190-11.(1)(a); or

(D) the company may conclude the loss settlement as provided for under the appraisal section of the insurance contract in force at the time of the loss. The company is not required to take action under this subsection if its documentation to the first party claimant, at the time of settlement, included written notification of the availability and location of a specified and comparable vehicle of the same manufacturer, same year, similar body style and similar options in as good or better condition as the total loss vehicle which could be purchased for the market value determined by the company before applicable deductions.

(c) when a first party claimant automobile total loss is settled on a basis which deviates from the methods described in Subsections R590-190-11.(1)(a) and (b), the deviation must be supported by documentation giving particulars of the automobile condition. Any deductions from such cost, including deductions for salvage, must be measurable, itemized and specified as to dollar amount and shall be appropriate in amount. The basis for such settlement shall be fully explained to the first party claimant.

(2) Total loss settlements with a third party claimant shall be on the basis of the market value or actual cost of a comparable automobile at the time of loss. Settlement procedures shall be in accordance with Subsection R590-190-11.(1)(b) and (c), except (b)(v) shall not apply.

(3) Where liability and damages are reasonably clear, insurers are prohibited from recommending that third party claimants make a claim under their own policies solely to avoid paying claims under such insurer's insurance policy or insurance contract.

(4) Insurers are prohibited from requiring a claimant to travel an unreasonable distance to inspect a replacement automobile, to obtain a repair estimate or to have the automobile repaired at a specific repair shop.

(5) Insurers shall include the first party claimant's deductible, if any, in subrogation demands initiated by the insurer. Subrogation recoveries may be shared on a proportionate basis with the first party claimant when an agreement is reached for less than the full amount of the loss, unless the deductible amount has been otherwise recovered. The recovery shall be

applied first to reimburse the first party claimant for the amount or share of the deductible when the full amount or share of the deductible has been recovered. No deduction for expenses can be made from the deductible recovery unless an outside attorney is retained to collect such recovery. The deduction may then be for only a pro rata share of the allocated loss adjustment expense. If subrogation is initiated but discontinued, the insured shall be advised.

(6) If an insurer prepares or approves an estimate of the cost of automobile repairs, such estimate shall be in an amount for which it may be reasonably expected the damage can be satisfactorily repaired. If the insurer prepares an estimate, it shall give a copy of the estimate to the claimant and may furnish to the claimant the names of one or more conveniently located repair shops.

(7) When the amount claimed is reduced because of betterment or depreciation, all information for such reduction shall be contained in the claim file. Such deductions shall be itemized and specified as to dollar amount and shall be appropriate for the amount of deductions. The insurer shall provide a written explanation of these deductions to the claimant upon request.

(8) When the insurer elects to repair and designates a specific repair shop for automobile repairs, the insurer shall cause the damaged automobile to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy and within a reasonable period of time.

(9) Where coverage exists, loss of use payment shall be made to a claimant for the reasonably incurred cost of transportation, or for the reasonably incurred rental cost of a substitute vehicle, including collision damage waiver, unless the claimant has physical damage coverage available, during the period the automobile is necessarily withdrawn from service to obtain parts or effect repair, or, in the event the automobile is a total loss and the claim has been timely made, during the period from the date of loss until a reasonable settlement offer has been made by the insurer. The insurer is prohibited from refusing to pay for loss of use for the period that the insurer is examining the claim or making other determinations as to the payability of the loss, unless such delay reveals that the insurer is not liable to pay the claim. Loss of use payments shall be an amount in addition to the payment for the value of the automobile.

(10) Subject to Subsections R590-190-11.(1) and (2), an insurer shall fairly, equitably and in good faith attempt to compensate a claimant for all losses incurred under collision or comprehensive coverages. Such compensation shall be based at least, but not exclusively, upon the following standards:

(a) an offer of settlement may not be made exclusively on

the basis of useful life of the part or vehicle damaged;

(b) an estimate of the amount of compensation for the claimant shall include the actual wear and tear, or lack thereof, of the damaged part or vehicle;

(c) actual cash value, which shall take into account the cost of replacement of the vehicle and/or the part for which compensation is claimed;

(d) an actual estimate of the true useful life remaining in the part or vehicle shall be taken into account in establishing the amount of compensation of a claim; and

(e) actual cash value, which shall include taxes and other fees which shall be incurred by a claimant in replacing the part or vehicle or in compensating the claimant for the loss incurred.

(11) Insurers are prohibited from demanding reimbursement of personal injury protection payments from a first-party insured of payments received by that party from a settlement or judgement against a third party, except as provided by law.

(12) The insurer shall provide reasonable written notice to a claimant prior to termination of payment for automobile storage charges and documentation of the denial as required by Section R590-190-4. Such insurer shall provide reasonable time for the claimant to remove the vehicle from storage prior to the termination of payment.

R590-190-12. Unfair Claims Settlement Practices Applicable to Automobile Insurance.

The commissioner, pursuant to Section 31A-26-303(4), hereby finds the following acts, or the failure to perform required acts, to be misleading, deceptive, unfairly discriminatory or overreaching in the settlement of claims:

(1) using as a basis for cash settlement with a claimant an amount which is less than the amount which the insurer would be charged if repairs were made, unless such amount is agreed to by the claimant or provided for by the insurance policy;

(2) refusing to settle a claim based solely upon the issuance of, or failure to, issue a traffic citation by a police agency;

(3) failing to disclose all coverages for which an application for benefits is required by the insurer;

(4) failing in good faith to disclose all coverages, including loss of use, household services, and any other coverages available to the claimant;

(5) requiring a claimant to use only the insurer's claim service in order to perfect a claim;

(6) failing to furnish the claimant, when requested, with the name and address of the salvage dealer who has provided a salvage quote for the amount deducted by the insurer in a total

loss settlement;

(7) refusing to disclose policy limits when requested to do so by a claimant or claimant's attorney;

(8) using a release on the back of a check or draft which requires a claimant to release the company from obligation on further claims in order to process a current claim when the company knows or reasonably should know that there will be future liability on the part of the insurer;

(9) refusing to use a separate release of a claim document rather than one on the back of a check or draft when requested to do so by a claimant;

(10) intentionally offering less money to a first party claimant than the claim is reasonably worth, a practice referred to as "low-balling;"

(11) refusing to offer to pay claims based upon the Doctrine of Comparative Negligence without a reasonable basis for doing so; and

(12) imputing the negligence of a permissive user of a vehicle to the owner of the vehicle in a bailment situation.

R590-190-13. Standards for Prompt, Fair and Equitable Settlements Applicable to Fire and Extended Coverage Type Policies with Replacement Cost Coverage.

(1) Replacement Cost Value:

When the policy provides for the adjustment and settlement of first party losses based on replacement cost, the following shall apply:

(a) when a loss requires repair or replacement of an item or part, any consequential physical damage incurred in making such repair or replacements not otherwise excluded by the policy, shall be included in the loss. The insured is only responsible for the applicable deductible; and

(b) when a loss requires replacement or repair of items and the repaired or replaced items do not match in color, texture, or size, the insurer shall repair or replace items so as to conform to a reasonably uniform appearance. This applies to interior and exterior losses. The insured is only responsible for the applicable deductible.

(2) Actual Cash Value:

(a) When the insurance policy provides for the adjustment and settlement of losses on an actual cash value basis on residential fire and extended coverage, the insurer shall determine actual cash value as the replacement cost of property at the time of the loss less depreciation, if any. Upon the insured's request, the insurer shall provide a copy of relevant documentation from the claim file detailing any and all deductions for depreciation.

(b) In cases in which the insured's interest is limited because the property has nominal or no economic value, or a value disproportionate to replacement cost less depreciation, the determination of actual cash value, as set forth above, is not required. In such cases, the insurer shall provide, upon the insured's request, a written explanation of the basis for limiting the amount of recovery along with the amount payable under the policy.

R590-190-14. Severability.

If any provision or clause of this rule or its application to any person or situation is held invalid, such invalidity may not affect any other provision or application of this rule which can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.

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