INSURANCE

CHAPTER 318

HOUSE BILL NO. 1238
(Committee on Industry, Business, and Labor)
(At the request of the Commissioner of Insurance)

INSURANCE POLICY DECLINATION AND CANCELLATION

AN ACT to create and enact subsections 4 and 5 to section 26-02-32, sections 26-02-38.1, 26-02-38.2, 26-02-38.3, 26-02-47, 26-02-48, 26-02-49, 26-02-50, 26-02-51, 26-02-52, 26-02-53, 26-02-54, 26-02-55, 26-02-56, 26-02-57, 26-02-58, 26-02-59, and 26-02-60 of the North Dakota Century Code, relating to the declination, termination, and cancellation of property and casualty insurance policies; to amend and reenact sections 26-02-33, 26-02-34, 26-02-35, 26-02-36, and 26-02-38 of the North Dakota Century Code, relating to the declination, termination, and cancellation of automobile insurance policies; and to provide a penalty.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. Subsections 4 and 5 to section 26-02-32 of the North Dakota Century Code are hereby created and enacted to read as follows:

4. "Termination" means either a cancellation or nonrenewal of automobile insurance coverage in whole or in part. A cancellation occurs during the policy term. A nonrenewal occurs at the end of the policy term. An insurer's substitution of insurance upon renewal which results in substantially equivalent coverage shall not be considered a termination.

5. "Declination" means the refusal of an insurer to issue an automobile insurance policy upon receipt of a written nonbinding application or written request for coverage from its agent or an applicant. For the purposes of sections 26-02-32 through section 26-02-38.3, the offering of insurance coverage with a company within an insurance group which is different from the company requested on the nonbinding application or written request for coverage, or the offering of policy coverage or rates substantially less favorable than requested in the nonbinding

application or written request for coverage, shall be considered a declination.

SECTION 2. AMENDMENT. Section 26-02-33 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-02-33. Cancellation of policy - Exclusive reasons therefor.

1. No insurer shall cancel a policy except for the following reasons:

   a. Nonpayment of premium.

   b. Because the driver's license or motor vehicle registration of either the named insured or any other operator who resides in the same household as the named insured or who customarily operates a motor vehicle insured under the policy has been suspended, rescinded, canceled, or revoked during the policy period, or, if the policy is a renewal, during its policy period or for one hundred eighty days immediately preceding its effective date. This subdivision shall not apply and the insurer shall not cancel a policy where the operator whose driver's license is suspended or revoked is excluded from coverage under the policy. The insurer shall notify the named insured of the possibility of excluding an operator whose license has been suspended or revoked prior to cancellation of the policy. When an operator whose driver's license is suspended or revoked is excluded from coverage under the policy covering a secured motor vehicle, the owner of such motor vehicle who gives his expressed or implied consent to such operator to use said motor vehicle is not relieved of his liability under subsection 5 of section 26-41-04.

   c. Fraud or material misrepresentation made by or with the knowledge of any insured in obtaining the policy, continuing the policy, or in presenting a claim under the policy.

   d. The insured motor vehicle is:

      (1) So mechanically defective that its operation might endanger public safety;

      (2) Used in carrying passengers for hire or compensation, provided, however, that the use of an automobile for a car pool shall not be considered use of an automobile for hire or compensation;

      (3) Used in the transportation of flammables or explosives or for an illegal purpose;

(4) An authorized emergency vehicle; or

(5) Altered by an insured during the policy period so as to substantially increase the risk.

e. The named insured moves to a state where the insurer is not licensed to do business.

f. Failure to pay dues or fees where payment of such dues or fees is a prerequisite to obtaining or continuing automobile insurance coverage.

g. A determination by the commissioner of insurance that the continuation of the policy would place the insurer in violation of the law or would be hazardous to the interests of policyholders, creditors, or the public.

2. During the policy period no modification of automobile physical damage coverage, except coverage for loss caused by collision, whereby provision is made for the application of a deductible amount not exceeding one hundred dollars shall be deemed a cancellation of the coverage or of the policy.

3. Renewal of a policy shall not constitute a waiver of estoppel with respect to grounds for cancellation which existed before the effective date of such renewal.

4. This section shall not apply to the failure to renew a policy.

SECTION 3. AMENDMENT. Section 26-02-34 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-02-34. Notice of cancellation - Statement of reasons therefor. No insurer shall exercise its right to cancel a policy unless a written notice of cancellation is mailed ~~by certified mail, return receipt requested,~~ or delivered to the named insured, at the address shown in the policy, at least twenty days prior to the effective date of cancellation~~, provided that if the mailing receipt has not been returned to the insurer within twenty days, and the insurer, through its local agent or otherwise, has made every reasonable effort during that period to notify the insured of the forthcoming cancellation, then the insurer may cancel the policy~~. When cancellation is for nonpayment of premium such notice shall be mailed ~~by certified mail~~ or delivered to the named insured at the address shown in the policy at least ten days prior to the effective date of cancellation and shall include or be accompanied by a statement of the reason therefor. This section shall not apply to the failure to renew a policy.

SECTION 4. AMENDMENT. Section 26-02-35 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-02-35. Statement of reasons to accompany notice of cancellation or to be mailed upon request of insured. The notice of cancellation shall state or be accompanied by either a statement of the reason or reasons therefor, or a statement that upon written request of the named insured, ~~mailed or delivered to the insurer at least ten days prior to the effective date of cancellation,~~ the insurer will specify in writing the reason or reasons for such cancellation. ~~If the reason or reasons for cancellation do not accompany or are not included in the notice of cancellation, the insurer shall upon such written request of the named insured specify in writing the reason or reasons for cancellation.~~ The written request must be mailed or delivered to the insurer at least ten days prior to the effective date of cancellation. The insurer shall mail or deliver such reason or reasons to the named insured within ten days after receipt of such written request. Failure to comply with the notice of cancellation provisions of section 26-02-34, or failure to furnish reasons for cancellation upon written request of the insured shall be sufficient cause for the commissioner of insurance to cancel, revoke, or refuse to renew that company's certificate of authority to do business in North Dakota. This section shall not apply to failure to renew a policy.

SECTION 5. AMENDMENT. Section 26-02-36 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-02-36. Nonrenewal - Notice - Statement of reasons - Nonrenewal not to be based on certain facts - Responsibility of commissioner.

1. No insurer shall fail to renew a policy unless a written notice of nonrenewal is mailed or delivered to the named insured, at the address shown in the policy, at least ~~twenty~~ thirty days prior to the expiration date of the policy or anniversary date of a policy written for a term longer than one year or with no fixed expiration date. The insurer shall include a statement of the reasons for nonrenewal with the notice, or shall furnish it upon the written request of the insured mailed or delivered to the insurer at least ten days prior to the expiration date of the policy. The insurer shall comply with such a request within ten days after receipt thereof.

2. Subsection 1 shall not apply to any of the following:

   a. If the insurer has manifested in any way its willingness to renew.

   b. In case of nonpayment of premium for the expiring policy.

   c. If the insured fails to pay the premium as required by the insurer for renewal.

~~3. No insurer authorized to do business in this state shall refuse to renew an automobile liability insurance policy~~

~~solely because of the age, residence, race, color, creed, sex, national origin, ancestry, or occupation of anyone who is an insured.~~

~~4. An insurer found guilty of willfully violating the provisions of subsection 3 shall be guilty of a class A misdemeanor. Failure on the part of an insurer to comply with the provisions of subsections 1 and 3 shall be sufficient cause for the insurance commissioner to cancel, revoke, or refuse to renew that insurer's certificate of authority to do business in North Dakota.~~

SECTION 6. AMENDMENT. Section 26-02-38 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-02-38. Proof of notice of ~~cancellation or nonrenewal~~ termination. ~~Proof of mailing of notice of cancellation for nonpayment of premium, or of nonrenewal or of reasons for cancellation,~~ A post-office department certificate of mailing to the named insured at the address shown in the policy, shall be sufficient proof of notice. Proof of ~~mailing of notice of cancellation for reasons other than nonpayment of premium shall be evidenced by the return receipt provided for in section 26-02-34, or by affidavit of mailing.~~ mailing a notice of cancellation or a notice of an intention not to renew, or business records of the notice of the insured's willingness to renew, shall be retained for a period of one year by the insurer or agent or broker giving such notice.

SECTION 7. Section 26-02-38.1 of the North Dakota Century Code is hereby created and enacted to read as follows:

26-02-38.1. Notification and reasons for a declination.

1. Upon declining an application or written request for an automobile insurance policy subject to this Act the insurer making such declination shall either provide the insurance applicant with the specific reasons in writing for the declination at the time of the declination or advise the applicant in writing that specific written reasons for the declination will be provided within twenty-one days of the timely receipt by the insurer making the declination of the applicant's written request for such reasons. An applicant's written request shall be timely under this subsection if received within ninety days of the date of the notice to the applicant.

2. No insurer not represented by an agent or broker, may refuse to provide an insurance application form or other means of making a written request for insurance to a prospective applicant who requests insurance coverage from the insurer.

3. No agent or broker, for any reason set out in section 26-02-38.2, may refuse to provide an insurance application form or other means of making a written request for insurance to a prospective applicant who requests insurance coverage from the agent, broker, or insurer.

SECTION 8. Section 26-02-38.2 of the North Dakota Century Code is hereby created and enacted to read as follows:

26-02-38.2. Terminations - Declinations - Prohibited reasons. The declination of an application for, or the termination of, a policy of automobile insurance subject to sections 26-02-33 through 26-02-38.3 by an insurer, agent, or broker is prohibited if the declination or termination is:

1. Based upon the race, religion, nationality, or ethnic group, of the applicant or named insured.

2. Based solely upon the lawful occupation or profession of the applicant or named insured, except that this provision shall not apply to any insurer, agent, or broker which limits its market to one lawful occupation or profession or to several related lawful occupations or professions.

3. Based upon the principal location of the insured motor vehicle unless such decision is for a business purpose which is not mere pretext for unfair discrimination.

4. Based solely upon the age, sex, or marital status of an applicant or an insured, except that this subsection shall not prohibit rating differentials based on age, sex, or marital status.

5. Based upon the fact that the applicant or named insured previously obtained insurance coverage through a residual market insurance mechanism.

6. Based upon the fact that another insurer previously declined to insure the applicant or terminated an existing policy in which the applicant was the named insured.

SECTION 9. Section 26-02-38.3 of the North Dakota Century Code is hereby created and enacted to read as follows:

26-02-38.3. Sanctions. If the commissioner after hearing determines that an insurer has violated section 26-02-33 or 26-02-38.2, the commissioner may require the insurer to: accept the application or written request for insurance coverage at a rate and on the same terms and conditions as are available to its other risks with similar characteristics, or reinstate insurance coverage to the end of the policy period; or continue insurance coverage at a rate and on the same terms and conditions as are available to its other risks with similar characteristics. If the commissioner has determined, after hearing, that any person has violated any

provision of sections 26-02-33 through 26-02-38.3, the commissioner may: issue a cease and desist order to restrain such person from engaging in practices which violate these sections, or assess a penalty against such person of up to five hundred dollars for each violation of these sections, or assess a penalty against such person of up to five thousand dollars for each willful and knowing violation of these sections, or cancel, revoke, or refuse to renew a company's certificate of authority to do business in this state.

SECTION 10. Section 26-02-47 of the North Dakota Century Code is hereby created and enacted to read as follows:

26-02-47. Property and casualty - Declination, cancellation, and nonrenewal - Scope. The provisions of sections 26-02-47 through 26-02-59 shall apply to policies of insurance or risks located or resident in this state which are issued and take effect or which are renewed after the effective date of sections 26-02-47 through 26-02-59 and insure against any of the following:

1. Loss of or damage to real property which consists of not more than four residential units, one of which is the principal place of residence of the named insured;

2. Loss of or damage to personal property owned by the named insured or used for personal, family, or household purposes within a residential dwelling;

3. Legal liability of the named insured arising out of bodily injury to or death of any persons or damage to property, except bodily injury, death, or property damage arising out of business pursuits or the rendering or failure to render professional services.

The provisions of sections 26-02-47 through 26-02-59 shall not apply to workmen's compensation policies, automobile policies, inland marine policies, policies of insurance issued through a residual market mechanism, or policies primarily insuring risks arising from the conduct of a commerical or industrial enterprise.

For purposes of sections 26-02-47 through 26-02-59, any policy period or term of less than six months shall be considered a policy period or term of six months and any policy period or term of more than one year or any policy with no fixed expiration date shall be considered a policy period or term of one year.

SECTION 11. Section 26-02-48 of the North Dakota Century Code is hereby created and enacted to read as follows:

26-02-48. Definitions.

1. "Declination" means the refusal of an insurer to issue a property insurance policy upon receipt of a written nonbinding application or written request for coverage from its agent or an applicant. For the purposes of

sections 26-02-47 through 26-02-59, the offering of insurance coverage with a company within an insurance group which is different from the company requested on the nonbinding application or written request for coverage or the offering of insurance upon different terms than requested in the nonbinding application or written request for coverage shall be considered a declination.

2. "Nonpayment of premium" means the failure of the named insured to discharge any obligation in connection with the payment of premiums on policies of property insurance subject to sections 26-02-47 through 26-02-59, whether such payments are directly payable to the insurer or its agent or indirectly payable under a premium finance plan or extension of credit. "Nonpayment of premium" includes the failure to pay dues or fees where payment of such dues or fees is a prerequisite to obtaining or continuing property insurance coverage.

3. "Renewal" or "to renew" means the issuance and delivery by an insurer at the end of a policy period of a policy superseding a policy previously issued and delivered by the same insurer, or the issuance and delivery of a certificate or notice extending the term of an existing policy beyond its policy period or term.

4. "Termination" means either a cancellation or nonrenewal of property insurance coverage in whole or in part. A cancellation occurs during the policy term. A nonrenewal occurs at the end of the policy term as set forth in subsection 1. For purposes of sections 26-02-47 through 26-02-59, the transfer of a policyholder between companies within the same insurance group shall be considered a termination. Requiring a reasonable deductible, reasonable changes in the amount of insurance, or reasonable reductions in policy limits or coverage shall not be considered a termination if such requirements are directly related to the hazard involved and are made on the renewal date for the policy.

SECTION 12. Section 26-02-49 of the North Dakota Century Code is hereby created and enacted to read as follows:

26-02-49. Notification and reasons for declination.

1. Upon declining to insure any real or personal property subject to sections 26-02-47 through 26-02-59, the insurer making such declination shall either provide the insurance applicant with a written explanation of the specific reasons for the declination at the time of the declination or advise the applicant that a written explanation of the specific reasons for the declination will be provided within twenty-one days of the time of the receipt of the applicant's written request for such an explanation. An

applicant's written request shall be timely under this section if received within ninety days of the date of that notice to the applicant.

2. No insurer not represented by an agent or broker, shall refuse to provide an insurance application form or other means of making a written request for insurance to a prospective applicant who requires insurance coverage from the insurer.

3. No agent or broker, for any reason set out in section 26-02-55, may refuse to provide an insurance application form or other means of making a written request for insurance to a prospective applicant who requests insurance coverage from the agent, broker, or insurer.

SECTION 13. Section 26-02-50 of the North Dakota Century Code is hereby created and enacted to read as follows:

26-02-50. Cancellation of policy. After coverage has been in effect for more than sixty days or after the effective date of a renewal policy, a notice of cancellation shall not be issued unless it is based on at least one of the following reasons:

1. Nonpayment of premium.

2. Discovery of fraud or material misrepresentation and the procurement of the insurance or with respect to any claims submitted thereunder.

3. Discovery of willful or reckless acts or omissions on the part of the named insured which increase any hazard insured against.

4. The occurrence of a change in the risk which substantially increases any hazard insured against after insurance coverage has been issued or renewed.

5. A violation of any local fire, health, safety, building, or construction regulation or ordinance with respect to any insured property or the occupancy thereof which substantially increases any hazard insured against.

6. A determination by the commissioner of insurance that the continuation of the policy would place the insurer in violation of the insurance laws of this state.

7. Conviction of the named insured of a crime having as one of its necessary elements an act increasing any hazard insured against.

SECTION 14. Section 26-02-51 of the North Dakota Century Code is hereby created and enacted to read as follows:

26-02-51. Notice of cancellation. No insurer shall exercise its right to cancel a policy unless a written notice of cancellation is mailed or delivered to the named insured, at the last known address of the named insured, at least thirty days prior to the effective date of cancellation or when the cancellation is for nonpayment of premium at least ten days prior to the effective date of cancellation.

A post-office department certificate of mailing to the named insured at his last known address shall be conclusive proof of mailing and receipt on a third calendar day after the mailing.

SECTION 15. Section 26-02-52 of the North Dakota Century Code is hereby created and enacted to read as follows:

26-02-52. Five-day notice exception for property insurance cancellation. Policies subject to sections 26-02-47 through 26-02-59 may be canceled upon five-days written notice to the named insureds if one or more of the following conditions exist:

1. Buildings with at least sixty-five percent of the rental units in the building unoccupied.

2. Buildings which have been damaged by a peril insured against and the insured has stated or such time has elapsed as clearly indicates that the damage will not be repaired.

3. Buildings to which, following a fire, permanent repairs have not commenced within sixty days following satisfactory adjustment of loss.

4. Buildings which have been unoccupied sixty consecutive days, except buildings which have a seasonal occupancy, and buildings actually in the course of construction or repair and reconstruction which are properly secured against unauthorized entry.

5. Buildings which are in danger of collapse because of serious structural conditions or those buildings subject to extremely hazardous conditions not contemplated in filed rating plans such as those buildings which are in a state of disrepair as to be dilapidated.

6. Buildings on which, because of their physical condition, there is an outstanding order to vacate, an outstanding demolition order, or which have been declared unsafe in accordance with applicable law.

7. Buildings from which fixed and salvageable items have been or are being removed and the insured can give no reasonable explanation for such removal.

8. Buildings on which there is reasonable knowledge and belief that the property is endangered and is not reasonably protected from possible arson for the purpose of defrauding an insurer.

9. Buildings with any of the following conditions:

   a. Failure to furnish heat, water, sewer service, or public lighting for thirty consecutive days or more;

   b. Failure to correct conditions dangerous to life, health, or safety;

   c. Failure to maintain the building in accordance with applicable law;

   d. Failure to pay property taxes for more than one year.

10. Buildings which have characteristics of ownership condition, occupancy, or maintenance which are violative of law or public policy.

SECTION 16. Section 26-02-53 of the North Dakota Century Code is hereby created and enacted to read as follows:

26-02-53. Statement of reasons to a company notice of cancellation or to be mailed upon request of insured. The notice of cancellation shall state or be accompanied by either a statement of the reason or reasons therefor, or a statement that upon written request of the named insured, the insurer will specify in writing the reason or reasons for such cancellation. The written request must be mailed or delivered to the insurer at least ten days prior to the effective date of cancellation or if cancellation occurs pursuant to section 26-02-52, within ten days from the effective date of cancellation. The insurer shall mail or deliver such reason or reasons to the named insured within ten days after receipt of such written request. This section shall not apply to failure to renew a policy.

SECTION 17. Section 26-02-54 of the North Dakota Century Code is hereby created and enacted to read as follows:

26-02-54. Nonrenewal - Notice - Statement of reasons.

1. No insurer shall fail to renew a policy unless a written notice of nonrenewal is mailed or delivered to the named insured, at the last known address of the named insured, at least thirty days prior to the expiration date of the policy. A post-office department certificate of mailing to the named insured at his last known address shall be conclusive proof of mailing and receipt on the third calendar day after the mailing.

2. The insurer shall include a statement of the reasons for a nonrenewal with the notice, or shall furnish it upon the written request of the insured. The written request must be mailed or delivered to the insurer at least ten days prior to the expiration date of the policy. The insurer shall comply with such a request within ten days after receipt thereof.

3. No notice of intention not to renew shall be required where the named insured is given notice of the insurer's willingness to renew the policy by the mailing or delivering of a renewal notice, bill, certificate, or policy. If notice as required by this subsection is not provided, coverage shall be deemed to be renewed for the ensuing policy period upon payment of the appropriate premium under the same terms and conditions, and subject to the provisions of section 26-02-50, until the named insured has accepted the replacement coverage with another insurer or until the named insured has agreed to the nonrenewal.

4. Proof of mailing a notice of intention not to renew or business records of the notice of the insurer's willingness to renew shall be retained for a period of not less than one year by the insurer or agent or broker giving such notice.

SECTION 18. Section 26-02-55 of the North Dakota Century Code is hereby created and enacted to read as follows:

26-02-55. Termination - Declinations - Prohibited reasons. The declination or termination of a policy of property insurance subject to sections 26-02-47 through sections 26-02-59 by an insurer, agent, or broker is prohibited if the declination or termination is:

1. Based upon the race, religion, nationality, ethnic group, age, sex, or marital status of the applicant or named insured.

2. Based solely upon the lawful occupation or profession of the applicant or named insured, except that this provision shall not apply to an insurer which limits its market to one lawful occupation or profession or to several related lawful occupations or professions.

3. Based upon the age or location of the residence of the applicant or named insured unless such decision is for a business purpose which is not a mere pretext for unfair discrimination.

4. Based upon the fact that another insurer previously declined to insure the applicant or terminated an existing policy in which the applicant was the named insured.

5. Based upon the fact that the applicant or named insured previously obtained insurance coverage through a residual market insurance mechanism.

SECTION 19. Section 26-02-56 of the North Dakota Century Code is hereby created and enacted to read as follows:

26-02-56. Enforcement provisions.

1. Whenever the commissioner, upon the filing of a complaint or through his own investigation has reason to believe that an insurer, agent, or broker has engaged in practices which violate the provisions of sections 26-02-47 through 26-02-59 and that a proceeding in respect thereto would be in the public interest, the commissioner shall conduct a hearing in accordance with the provisions of chapter 28-32.

2. If after hearing, the commissioner determines that an insurer has violated sections 26-02-50 and 26-02-54, the commissioner may require the insured to accept the application or written request for insurance coverage at a rate and on the same terms and conditions as are available to other risks similarily situated, or reinstate insurance coverage to the end of the policy period, or continue insurance coverage at a rate and on the same terms and conditions as are available to other risks similarily situated.

3. If the commissioner after hearing determines that any person has violated any provisions of sections 26-02-47 through 26-02-59, the commissioner may issue a cease and desist order to restrain such person from engaging in practices which violate these sections or assess a penalty against such person of up to five hundred dollars for each violation of the sections or for each willful and knowing violation of the provisions of these sections assess a penalty against such person of up to five thousand dollars or cancel, revoke, or refuse to renew a company's certificate of authority to do business in this state.

4. If the commissioner determines in a final order that an insurer has violated section 26-02-50 or 26-02-54, the applicant or named insured aggrieved by the violation may bring an action in a court of competent jurisdiction in this state to recover from such insurer any loss not otherwise recovered through insurance which would have been paid under the insurance coverage that was declined or terminated in violation of these sections.

5. Any amount recovered shall not be duplicative of any recovery obtained through the exercise of any other statutory, or common law cause of action arising out of the same occurrence. No action under this section shall

be brought two years after the date of a final order of the commissioner finding a violation of section 26-02-50 or 26-02-54.

SECTION 20. Section 26-02-57 of the North Dakota Century Code is hereby created and enacted to read as follows:

26-02-57. Immunity. There shall be no liability on the part of and no cause of action shall arise against:

1. The commissioner of insurance;

2. Any insurer or its authorized representatives, agents, or employees;

3. Any licensed insurance agent or broker; or

4. Any person furnishing information to an insurer as to reasons for a termination or declination, for any communication giving notice of or specifying the reasons for a declination or termination or for any statement made in connection with an attempt to discover or verify the existence of conditions which would be a reason for a declination or termination under these sections.

The above shall not apply to statements made in bad faith with malice in fact.

SECTION 21. Section 26-02-58 of the North Dakota Century Code is hereby created and enacted to read as follows:

26-02-58. Standard fire policy - Cancellation requirement superseded. The cancellation provisions contained in the standard fire policy set out in section 26-03-40 are superseded to the extent that the provisions of sections 26-02-47 through 26-02-59 are inconsistent therewith.

SECTION 22. Section 26-02-59 of the North Dakota Century Code is hereby created and enacted to read as follows:

26-02-59. Duplicate coverage. If an insured obtains a replacement policy which provides equal or more extensive coverage for any property covered in both policies, the first insurer's coverage of such property may be terminated either by cancellation or nonrenewal. Such termination shall be effective on the effective date of the policy providing duplicate coverage.

SECTION 23. Section 26-02-60 of the North Dakota Century Code is hereby created and enacted to read as follows:

26-02-60. Renewal - Waiver - Estoppel. Renewal of a policy shall not constitute a waiver or estoppel with respect to grounds for cancellation which existed before the effective date of the policy providing duplicate coverage.

Approved March 10, 1983

CHAPTER 319

HOUSE BILL NO. 1055
(Legislative Council)
(Interim Insurance Code Revision Committee)

INSURANCE CODE HOUSEKEEPING

AN ACT to create and enact section 26-18-13 of the North Dakota Century Code, relating to termination of fire and casualty insurance agency contracts; and to amend and reenact sections 4-36-26, 6-03-48, 6-05-01, 6-05-04, 6-05-08, 6-09.2-10, 6-09.4-15, 7-04-09, 10-30-14, subsection 14 of section 15-10-17, section 15-55-08, subsection 1 of section 23-17.2-03, sections 26-02-46, 26-03-39.3, 26-03-42, 26-03-48.1, subsection 2 of section 26-03.5-02, sections 26-09.2-06, 26-17.1-13, 26-17.1-16, 26-17.1-22, 26-39-02, 26-39-05, 37-03-13, 40-24-19, 40-33.2-10, 40-38.1-07, 40-58-11, 40-61-13, 43-13-31, 54-52-09, subsection 5 of section 54-52.1-01, and sections 54-52.1-10, 61-02-68.13, and 61-02-72 of the North Dakota Century Code, relating to references to insurance, insurance companies, and insurance laws.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 4-36-26 of the 1981 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

4-36-26. Bonds - Legal investments ~~for whom~~ - Considered securities. The bonds issued by and under the authority of this chapter by the commission are ~~declared to be~~ legal investments in which all public officers or public bodies of this state, its political subdivisions, all municipalities and municipal subdivisions, ~~all insurance companies and associations and other persons carrying on insurance business,~~ all banks, bankers, banking associations, trust companies, savings associations, including savings and loan associations, ~~building and loan associations,~~ investment companies, and other persons carrying on a banking business, all administrators, guardians, executors, trustees, and other fiduciaries, and all other persons who are now or may later be authorized to invest in bonds or in other obligations of this state, may invest funds, including capital, in their control or belonging to them. ~~Such~~ The bonds are ~~also hereby made~~ authorized securities which may be deposited with

and received by all public officers and bodies of this state or any agency or political subdivision of this state and all municipalities and public corporations for any purpose for which the deposit of bonds or other obligations of this state is now or may be later authorized by law.

SECTION 2. AMENDMENT. Section 6-03-48 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

6-03-48. Investment in notes or bonds secured by insured mortgage - Debentures of federal housing administrator authorized. ~~It shall be lawful for banks~~ Banks, savings banks, trust companies, ~~building~~ savings and loan associations, ~~insurance companies,~~ executors, administrators, guardians, trustees, and other fiduciaries, the state of North Dakota and its political subdivisions, institutions, and agencies thereof, and all other persons, associations, and corporations subject to the laws of this state ~~to~~ may invest the funds and moneys in their custody or possession eligible for investment in notes or bonds secured by mortgage or deed of trust insured by the federal housing administrator, in debentures issued by the federal housing administrator, and in securities issued by national mortgage associations.

SECTION 3. AMENDMENT. Section 6-05-01 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

6-05-01. Who may form - Corporation has perpetual existence. Any number of persons, not less than nine, at least three of whom must be residents of this state, may associate themselves and form a corporation for the purpose of transacting business as an annuity, safe deposit, ~~surety,~~ and trust company. Its existence shall be perpetual.

At the time and place stated, and through any sources of information at its command, the board diligently shall inquire whether the place where such company is proposed to be located is in need of a further annuity, safe deposit, ~~surety~~ and trust company, whether the proposed institution is adapted to the filling of such need, and whether the proposed incorporators are possessed of such character, integrity, reputation, and financial standing as shown by a detailed financial statement to be furnished by them, that their connection with the company will be beneficial to the public welfare of the community in which such company is proposed to be established. The board shall hear any reasons advanced by the applicants why they should be permitted to organize the proposed institution, and any reasons advanced by any person why such institution should not be permitted to be organized. At the termination of such hearing, the board shall make a brief statement in writing of its conclusions, and if it finds that the proposed institution should not be permitted to organize, it shall state briefly the reasons why. A copy of such conclusions either shall be endorsed upon or attached to the organization certificate, together with the refusal or grant of permission to the proposed incorporators to present the said organization certificate to the

secretary of state. A determination in favor of such organization must be joined in by all the members of the board.

Any banking association organized under chapter 6-02 ~~shall be entitled to transact business as a trust company upon making application~~ may apply to the state banking board for a hearing as provided for in this section and an order authorizing the applicant to transact business as a trust company. If the determination of the board is in favor of the applicant the board shall make its order authorizing the applicant to engage in the business of a trust company upon its showing full compliance with ~~the provisions of~~ sections 6-05-03, 6-05-04, and 6-05-05 except the capital stock of the banking association shall not be required to be divided in shares of one hundred dollars each as provided by section 6-05-03. ~~The provisions of sections~~ Sections 6-05-06 and 6-05-07 ~~shall~~ are not ~~be~~ applicable to banking associations granted authority to engage in the business of a trust company by the state banking board. Thereafter such banking association shall be subject to the jurisdiction of the state banking board as to its trust company operations the same as trust companies organized under chapter 6-05.

Any corporation organized and authorized to transact the business of fidelity insurance and corporate suretyship prior to July 1, 1983, pursuant to the former sections 6-05-08 and 6-05-19 through 6-05-24 and sections 6-05-30 through 6-05-33 may continue to operate under the provisions of those sections as they existed on June 30, 1983.

SECTION 4. AMENDMENT. Section 6-05-04 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

6-05-04. Surety deposit investments required - Securities in which investment may be made. Every corporation organized under ~~the provision of~~ this chapter ~~and not under the jurisdiction of the insurance commissioner~~ and every foreign corporation before engaging in similar comparable activities ~~excepting these foreign corporations qualified to act as surety or guarantor under the provisions of section 6-05-30~~ within this state shall either deposit with the state treasurer, with any federal reserve bank, or with the Bank of North Dakota, securities ~~of the amount of at least fifty thousand dollars, and such~~ as provided by this section. The deposit ~~shall at no time be permitted to~~ may not be less than ~~said amount~~ fifty thousand dollars or less than one-sixth of the par value of the capital stock of the corporation, whichever is the greater~~, but~~. However, no ~~such~~ corporation ~~shall be~~ is required to deposit more than five hundred thousand dollars. Where ~~such deposits are~~ the deposit is made with a federal reserve bank, the deposit certificate shall authorize the state treasurer to cause such deposit, in part or in whole, to be transferred to the state treasurer upon ~~his~~ the state treasurer's demand. An original of such certificate of deposit shall be furnished to the state treasurer. The securities so deposited shall be:

1. Bonds of the United States or of ~~the~~ this state ~~of North Dakota~~;

2. Bonds of other states which shall have the approval of the state auditor and the ~~state examiner~~ commissioner of banking and financial institutions;

3. Bonds or obligations of any township, school district, city, or county within this state, whose total bonded indebtedness does not exceed five percent of the then assessed valuation thereof;

4. Bonds or promissory notes secured by first mortgages or deeds of trust upon unencumbered real estate situated within the state of North Dakota worth two and one-half times the amount of the obligation so secured;

5. Obligations issued, assumed, or guaranteed by the International Bank for Reconstruction and Development; or

6. United States treasury bills or notes ~~or~~ of an agency thereof.

SECTION 5. AMENDMENT. Section 6-05-08 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

6-05-08. Corporate powers. ~~Such~~ A corporation, when qualified as provided by section 6-05-04, ~~shall have the power and authority~~ may:

1. ~~To acquire~~ Acquire, lease, purchase, own, hold, use, improve, mortgage, sell, and convey such real estate and personal property as may be necessary for the convenient transaction of its business. It may acquire real estate by foreclosure or upon compromise or settlement of prior mortgages held by it either as absolute owner or as trustee, and may dispose of the same. No part of the capital, deposits, trust funds, or property owned or held by ~~such corporation~~ it, in trust or otherwise, ~~shall~~ may be invested in real estate except as herein authorized, unless the investment is made under and by virtue of a particular contract, or instrument, or order, judgment, or decree of court, which ~~shall confer~~ confers a special power or authority so to do, and then only with, or to the extent of, the moneys or funds thereby provided and belonging to such particular trust. Such corporation is authorized to loan money and to purchase notes, bonds, mortgages, and other evidences of indebtedness, and other securities, subject to the limitations imposed upon banking associations as to investments, and to convert the same into cash and other securities~~;~~.

2. ~~To act~~ Act as trustee under will, agreement, court order, or otherwise, and ~~to~~ act as fiscal agent and transfer agent~~;~~.

3. ~~To take~~ Take, accept, and hold on deposit for savings account or for safekeeping, or in escrow, or for investment, any and all moneys, bonds, stocks, and other securities, or personal property whatsoever. When any savings deposit ~~shall have~~ has been received from a minor, the repayment of the ~~same~~ deposit to ~~such~~ the minor or his order ~~shall be~~ is a complete discharge of such corporation from any further liability therefor. Whenever any officer or person, public or private, or any fiduciary, ~~shall be~~ is authorized to pay into or deposit in any court any moneys, securities, or personal property whatsoever, the same instead of being deposited with or paid into court may be paid into or deposited with any corporation organized and acting under this chapter which may be designated for that purpose by the court having jurisdiction of the subject matter, or by the person owning or controlling such property. Whenever any fiduciary ~~shall deposit~~ deposits any moneys, securities, or any personal property whatsoever, belonging to his trust, with any corporation qualified and acting under this chapter and ~~shall take~~ takes a receipt of such corporation therefor, he and his sureties thereafter ~~shall be~~ are relieved from all liability therefor until the same again shall be delivered to him by such corporation~~;~~.

4. ~~To act~~ Act as assignee, receiver, administrator, executor, guardian, or conservator~~;~~.

5. ~~To provide~~ Provide by its bylaws and regulations for the payment of interest or dividends, for the investment of moneys, and conditions for repaying or withdrawing the same. It ~~shall have authority to~~ may borrow money upon the security of its own property or credit~~;~~.

6. ~~To act~~ Act as agent and attorney in fact in all respects as a natural person could do~~;~~.

7. ~~To make~~ Make, compile, and certify abstracts of title of real estate upon the conditions prescribed by the laws of this state relating to abstracters, to ensure the validity and genuineness of titles to real property~~;~~.

8. ~~To ensure and guaranty the fidelity and faithful performance of the duties and obligations of any public officer, person, company, or corporation, or of depositaries of public or other funds, and when the conditions of such bond or undertaking are guaranteed by a corporation organized under the provisions of this chapter, to which the certificate provided for in section 6-05-05 shall have been issued and shall be unrevoked, the~~

~~corporation shall be accepted as surety without further qualification. Nothing contained in this section shall apply to bonds given in criminal actions.~~

SECTION 6. AMENDMENT. Section 6-09.2-10 of the 1981 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

6-09.2-10. Bonds eligible for investment. Evidence of indebtedness bonds guaranteed by the commission under this chapter are ~~hereby made~~ legal investments for all ~~insurance companies,~~ trust companies, banks, investment companies, savings banks, ~~building and loan associations,~~ credit unions, savings and loan associations, executors, administrators, guardians, conservators, trustees and other fiduciaries, pension, profit-sharing, and retirement funds to the extent limited by law.

SECTION 7. AMENDMENT. Section 6-09.4-15 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

6-09.4-15. Bonds as legal investments and security. Notwithstanding any restrictions contained in any other law, the state and all public officers, boards, and agencies, and political subdivisions and agencies thereof, all national banking associations, state banks, trust companies, savings banks and institutions, ~~building and loan associations,~~ savings and loan associations, investment companies, and other persons carrying on a banking business, ~~all insurance companies, insurance associations and other persons carrying on an insurance business,~~ and all executors, administrators, guardians, trustees, and other fiduciaries, may legally invest any sinking funds, moneys, or other funds belonging to them or within their control in any bonds issued by the bond bank pursuant to this chapter, and ~~such~~ the bonds ~~shall be~~ are authorized security for any and all public deposits.

SECTION 8. AMENDMENT. Section 7-04-09 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

7-04-09. Shares - Fiduciaries, trustees, ~~insurance companies,~~ corporations, and banks - Investments. Administrators, executors, guardians, trustees, and other fiduciaries of every kind and nature, ~~insurance companies,~~ banks, and other financial institutions, charitable, educational, eleemosynary, and public corporations and organizations, municipalities, and public officials ~~are authorized to~~ may invest funds held by them, without any order of any court, in shares, certificates of deposit, and investment certificates of savings ~~and building~~ and loan associations which are under state supervision, and shares of federal savings and loan associations organized under the laws of the United States and under federal supervision, and such investments ~~shall be deemed and held to be~~ are legal investments for such funds. Whenever, under the laws of this state or otherwise, a deposit of securities is required for any purpose, the securities made legal investments by this section ~~shall be~~ are acceptable for ~~such deposits~~ the deposit, and whenever, under

the laws of this state or otherwise, a bond is required with security, ~~such~~ the bond may be furnished, and securities made legal investments by this section, in the amount of ~~such~~ the bond, when deposited therewith, ~~shall be~~ are acceptable as security without other security. ~~The provisions of this~~ This section ~~are~~ is supplemental to any ~~and all~~ other laws relating to and declaring what ~~shall be~~ are legal investments for the persons, corporations, organizations, and officials referred to in this section and to the laws relating to the deposit of securities and the making and filing of bonds for any purpose.

SECTION 9. AMENDMENT. Section 10-30-14 of the 1981 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

10-30-14. Notes or obligations - Legal investments. Notwithstanding any other statute, the notes or other interest-bearing obligations of a state development ~~corporations~~ corporation, issued in accordance with this chapter and the articles of incorporation and the bylaws of the corporation, ~~shall be~~ are legal investments for any banks, savings and loan associations, trust companies, ~~stock or mutual insurance companies,~~ or other financial institutions which become members of the corporation. The Bank of North Dakota and the North Dakota mill and elevator are each authorized to purchase capital stock and become members of the corporation.

SECTION 10. AMENDMENT. Subsection 14 of section 15-10-17 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

14. To insure itself and its employees and the officers, employees, and students, and any building or other property, real or personal, of any institution under its control against any loss or liability it deems advisable. If the board or any institution under its control purchases insurance pursuant to this subsection, the purchaser shall waive immunity to suit for liability only to the types of insurance coverage purchased and only to the extent of the policy limits of such coverage. For the public buildings, fixtures, and permanent contents therein described in chapter ~~26-24~~ 26.1-22, insurance secured under this subsection shall be supplemental to and not in lieu of ~~the provisions of~~ chapter ~~26-24~~ 26.1-22. If a premium savings will result, policies purchased hereunder may be taken out for more than one year, but in no event beyond a period of five years. Policies may be secured in individual or master policy form.

SECTION 11. AMENDMENT. Section 15-55-08 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

15-55-08. Who may invest in bonds. Any bank, or trust, ~~or insurance~~ company organized under the laws of this state may invest its capital and surplus in bonds issued under ~~the provisions of~~ this

chapter. Any state board, bureau, institution, or industry having the power to invest public funds or the funds of such board, bureau, institution, or industry may invest said funds in bonds issued pursuant to this chapter in the same manner and under the same restrictions as are provided by law for other investments. The officers having charge of any sinking fund of any county, city, town, township, or school district thereof may invest the sinking fund of such county, city, town, township, or school district in bonds issued under the provisions thereof. ~~Such~~ The bonds ~~shall also be approved as~~ are authorized collateral security for the deposit of any public funds and for the investment of trust funds.

SECTION 12. AMENDMENT. Subsection 1 of section 23-17.2-03 of the 1981 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

1. The department, pursuant to this chapter and ~~state~~ rules of the health ~~council's regulations, shall~~ council, must review proposals subject to this chapter and ~~shall determine certificate of need approval~~ must approve, disapprove, or revoke ~~a~~ the certificate of need, as appropriate. The certificate of need program applies to:

   a. The obligation by or on behalf of a health care facility of any capital expenditure (other than to acquire an existing facility). The costs of designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, or replacement of any plant or equipment.

   b. The obligation of any capital expenditure by or on behalf of a health care facility which:

      (1) Increases or decreases the total number of beds by ten beds or ten percent, whichever is less in any two-year period;

      (2) Redistributes beds among various categories by ten beds or ten percent, whichever is less in any two-year period; or

      (3) Relocates beds from one physical facility or site to another by ten beds or ten percent whichever is less in any two-year period.

   c. The addition of a health care service by or on behalf of a health care facility which was not offered within the previous twelve-month period before the month in which the service would be offered which is associated with either a capital expenditure or entails an annual operating cost of at least seventy-five thousand dollars; or the termination of a health service which is associated with any capital expenditure.

d. The acquisition by any person of major medical equipment that will be owned by or located in a health care facility.

e. The acquisition by any person of major medical equipment not owned by or located in a health care facility if:

(1) A notice of intent is not filed at least thirty days before a contract is entered into; or

(2) The department finds, within thirty days after receipt of a notice that the equipment will be used to provide services to inpatients on other than a temporary basis as in the case of a natural disaster, a major accident, or equipment failure.

f. The obligation of a capital expenditure by any person to acquire an existing health care facility if a notice of intent is not received ~~(~~at least thirty days prior to entering into a contract~~)~~ or the department finds that the services or bed capacity of the facility will be changed.

g. An acquisition by donation, lease, transfer, or comparable arrangement must be reviewed if such acquisition would have been subject to review if purchased. An acquisition for less than fair market value must be reviewed if the acquisition at fair market value would exceed the expenditure minimum.

However, health care facilities and health care services, for the purposes of this chapter, do not include health maintenance organizations, as defined in ~~subsection 7 of~~ section ~~26-38-01~~ 26.1-18-01, when the health maintenance organization, or other entity, is engaged in activities to determine the feasibility of developing and operating or expanding the operation of health maintenance organizations, or planning projects for the establishment of health maintenance organizations or for the significant expansion of the membership of, or areas served by, health maintenance organizations, or initial development of health maintenance organizations. "Planning projects" and "initial development" mean those activities as defined in the Health Maintenance Organization Act of 1973, as amended [Pub. L. 94-460; 90 Stat. 1948, 1950, 1955; and Pub. L. 95-559; 92 Stat. 2131, 2134; 42 U.S.C. 300 e-3].

SECTION 13. AMENDMENT. Section 26-02-46 of the 1981 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-02-46. "Legal expense insurance" defined. Legal expense insurance, as authorized in this title, means insurance which involves the assumption of a contractual obligation to reimburse the beneficiary against or on behalf of the beneficiary, all or a portion of ~~his~~ the beneficiary's fees, cost, or expenses related to or arising out of services by or under the supervision of an attorney licensed to practice law in this state, regardless of whether the payment is made by the beneficiaries individually or by a third party for them, but does not include the provision of or reimbursement for legal services incidental to other insurance coverages. Unless otherwise provided, this title ~~shall~~ does not apply to:

1. Plans licensed under chapter ~~26-27.3~~ 26.1-19.

2. Retainer contracts made by attorneys with individual clients with fees based upon an estimate of the nature and amount of services to be provided to a specific client and similar contracts made with a group of clients involved in the same or closely related legal matters.

3. Employee welfare benefit plans as defined by the Employee Retirement Income Security Act of 1974 [Pub. L. 93-406; 88 Stat. 829].

SECTION 14. AMENDMENT. Section 26-03-39.3 of the 1981 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-03-39.3. Individual or group insurer or nonprofit ~~medical or hospital~~ health service corporation responsibility - Release of information to ~~social service board of North Dakota~~ department of human services.

1. Any individual or group accident and sickness insurer or nonprofit ~~medical or hospital~~ health service corporation, upon request of the ~~social service board of North Dakota, shall~~ department of human services, must provide any information contained in its records pertaining to an individual who is an applicant for or recipient of medical assistance under chapter 50-24.1, and who is covered under an accident and sickness insurance policy or ~~nonprofit~~ a medical service or hospital service ~~corporation~~ contract issued by the insurer or nonprofit health service corporation or the medical benefits paid by or claims paid to the insured or subscriber under a policy or contract. The insurer or nonprofit ~~medical or hospital~~ health service corporation ~~shall~~ must make the requested records or information available upon receipt of a certification by the ~~social service board of North Dakota~~ department of human services that the individual is an applicant for or recipient of medical assistance under chapter 50-24.1, or is a person who is legally responsible for such an applicant or recipient.

2. The information required to be made available pursuant to this section ~~shall be~~ is limited to information necessary to determine whether benefits under the policy or contract have been or should have been claimed and paid pursuant to an accident and sickness insurance policy or ~~nonprofit~~ medical or hospital service ~~corporation~~ contract with respect to items of medical care and services received by a particular individual for which medical assistance coverage would otherwise be available.

3. The ~~social service board of North Dakota shall~~ department of human services must, in consultation with the commissioner ~~of insurance~~, establish guidelines:

   a. For the method of requesting and furnishing appropriate information, the time in which ~~such~~ the information is to be provided, and method of reimbursing insurance companies and nonprofit ~~medical or hospital~~ health service corporations for necessary costs incurred in furnishing the requested information.

   b. To assure that information relating to an individual certified to be an applicant for or recipient of medical assistance under chapter 50-24.1, furnished to an insurer or subscriber pursuant to this section, is used only for the purpose of identifying the records or information requested in such manner so as not to violate section 50-06-15.

SECTION 15. AMENDMENT. Section 26-03-42 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-03-42. Policy forms to be filed with commissioner ~~of insurance~~. ~~No~~ A policy of insurance ~~shall~~ may not be issued or delivered in this state until the form of that policy has been filed with the commissioner ~~of insurance~~. If the policy of insurance is a casualty or fire and property insurance policy, the form shall be filed with the commissioner ~~of insurance~~ to the extent rates are filed and approved pursuant to ~~chapters 26-28 and 26-29~~ chapter 26.1-25. If the policy of insurance is a policy against loss or damage by the sickness, bodily injury, or death by accident of the insured, a table of rates and classification of risks shall also be filed with the commissioner ~~of insurance~~. The commissioner ~~of insurance~~ shall review ~~such~~ the policy forms and shall approve or disapprove the policy forms as soon as reasonably practicable or within a period of forty-five days.

SECTION 16. AMENDMENT. Section 26-03-48.1 of the 1981 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-03-48.1. Coordination of benefits - Limitations. ~~No~~ A group or individual policy of accident and sickness insurance offered for

sale in this state ~~shall~~ may not be issued or renewed by any insurer or ~~hospital~~ any health service corporation ~~or medical service corporation~~ writing hospital service or medical service contracts transacting business in this state which by the terms of the policy excludes or reduces the benefits payable or services to be rendered to or on behalf of any insured because benefits have been paid or are also payable under any individually underwritten and individually issued contract or plan of insurance which provides exclusively for accident and sickness benefits, irrespective of the mode or channel of premium payment, with or without payroll deduction, to the insurer and regardless of any reduction in the premium by virtue of the insured's membership in any organization or of ~~his~~ the insured's status as an employee.

~~Nothing in this~~ This section ~~shall~~ does not affect the practice of coordination of benefits between group policies as provided in sections 26-03-48~~,~~ ~~26-26-15,~~ and ~~26-27-15~~ 26.1-17-17.

SECTION 17. AMENDMENT. Subsection 2 of section 26-03.5-02 of the 1981 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

2. "Company" or "insurer" means any life or health insurance company, fraternal benefit society, nonprofit health service corporation, ~~nonprofit hospital service corporation, nonprofit medical service corporation,~~ prepaid health plan, dental care plan, vision care plan, pharmaceutical plan, health maintenance organization, and all similar type organization.

SECTION 18. AMENDMENT. Section 26-09.2-06 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-09.2-06. Service of process. Any company desiring to transact any business under the terms of this chapter, by any surplus lines insurance broker or brokers in this state, shall appoint in writing the commissioner ~~of insurance to be~~ as its true and lawful attorney, upon whom legal process in any action or proceeding against it shall be served, and in ~~such~~ the writing, shall agree that any legal process against it, which is served upon ~~such~~ the attorney, ~~shall be~~ is of the same legal force and validity as if served upon ~~such~~ the company, and that ~~said~~ the authority ~~shall continue~~ continues in force so long as any liability remains outstanding in this state. Copies of ~~such~~ the appointment certified by the commissioner ~~of insurance shall be deemed~~ are sufficient evidence thereof and shall be admitted in evidence with the same force and effect as the original ~~thereof might be admitted. Such service must be made in duplicate upon the commissioner of insurance or, in his absence, upon the person in charge of his office, and shall be deemed sufficient service upon such company. When legal process against such company is served upon the commissioner of insurance he shall forthwith forward by registered or certified mail one of the duplicate copies, prepaid, and directed to its secretary or~~

~~corresponding officer. For each copy of process the commissioner of insurance shall collect two dollars which shall be paid by the plaintiff at the time of such service, the same to be recovered by him as part of the taxable costs if he prevails in the suit.~~ Legal process ~~shall~~ may not be served upon ~~such~~ the company except ~~in the manner~~ as provided ~~herein~~ by this section. In any suit on a policy on behalf of the owner or holder thereof, the service of process shall be made as ~~in~~ provided by this section ~~provided~~, but the action must be prosecuted in the county of the policyholder's residence.

* SECTION 19. AMENDMENT. Section 26-17.1-13 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-17.1-13. Term of license. All licenses issued pursuant to this chapter shall continue in force not longer than twelve months, but shall expire as of 12:01 a.m. on the first day of May next following date of issuance unless the licensee prior thereto has filed with the commissioner, on forms prescribed and furnished by ~~him~~ the commissioner, a request for renewal of ~~such~~ the license for an ensuing twelve-month period. ~~Such~~ The request must be accompanied by payment of the renewal fee as provided in section ~~26-01-04~~ 26.1-01-07.

SECTION 20. AMENDMENT. Section 26-17.1-16 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-17.1-16. Fees - Failure to pay. All applications shall be accompanied by the applicable fees as provided in section ~~26-01-04~~ 26.1-01-07. An appointment ~~shall terminate~~ terminates upon failure to pay the prescribed annual renewal fee.

SECTION 21. AMENDMENT. Section 26-17.1-22 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-17.1-22. License requirement - Nonresident - Designation of commissioner as attorney for service of process - Fee. The commissioner ~~shall~~ may not issue a license to any nonresident applicant until ~~he~~ the applicant files with the commissioner ~~his~~ a designation of the commissioner and ~~his~~ the commissioner's successors in office, ~~to be his~~ as the applicant's true and lawful attorney, upon whom may be served all lawful process in any action, suit, or proceeding instituted by or on behalf of any interested person arising out of the applicant's insurance business in this state. ~~Such~~ The designation ~~shall constitute~~ constitutes an agreement that ~~such~~ the service of process is of the same legal force and validity as personal service of process in this state upon ~~such~~ the person.

~~Such service of process upon any such licensee in any such action or proceeding in any court of competent jurisdiction of this state may be made by serving the commissioner with appropriate~~

* NOTE: Section 26-17.1-13 was also amended by section 4 of House Bill No. 1227, chapter 326.

~~copies thereof and the payment to him of a fee of two dollars. The commissioner shall forward a copy of such process by registered or certified mail to the licensee at his last known address of record or principal place of business, and shall keep a record of all process so served upon him.~~

SECTION 22. Section 26-18-13 of the North Dakota Century Code is hereby created and enacted to read as follows:

26-18-13. Termination of fire and casualty insurance agency contracts. Any insurance company authorized to transact fire or casualty business in this state shall, upon termination of an agent's appointment by the company, permit the renewal and endorsement of all contracts of insurance written by the agent for a period of one year from the date of the termination, as determined by the individual underwriting requirements of the company. If any contract does not meet the underwriting requirements, the company shall give the agent sixty days' notice of its intention not to renew the contract. This section does not apply if the contract is terminated because of the agent's failure, after receiving a written demand, to pay over moneys due the insurer.

SECTION 23. AMENDMENT. Section 26-39-02 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-39-02. Insurance companies to comply with chapter. ~~No~~ An insurance company, ~~nonprofit hospital service corporation,~~ or nonprofit ~~medical~~ health service corporation authorized to do business within this state ~~shall~~ may not deliver, issue, execute, or renew any policy of health insurance on a group or blanket or franchise or association basis where more than fifty persons are covered or are to be covered by ~~such~~ the policy and where the number of persons covered or to be covered represents more than seventy percent of all persons eligible for ~~such~~ the coverage unless ~~such~~ the policy ~~shall conform~~ conforms to the requirements of this chapter.

SECTION 24. AMENDMENT. Section 26-39-05 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-39-05. Other policies. ~~The provisions of this~~ This chapter ~~shall~~ does not ~~be construed to~~ prevent any insurance company or nonprofit ~~hospital or medical~~ health service corporation from issuing, delivering, or renewing, at its option, any policy or contract containing provisions similar to those required by this chapter, where ~~such~~ the policy or contract is not subject to such provisions.

SECTION 25. AMENDMENT. Section 37-03-13 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

37-03-13. Adjutant general to control military installations - Maintenance fund - Insurance. The adjutant general of the state of North Dakota shall have full control of Camp Gilbert C. Grafton, Ramsey County,

Fraine Barracks, Burleigh County, national guard air base facilities constituting a portion of Hector Airfield in Cass County, all in North Dakota and such other real property, installations, and facilities that may be acquired or leased by this state or the office of the adjutant general for military purposes. All moneys received from the sale of timber, stone, agricultural products, or other material taken from the properties and the proceeds of any leases or subleases thereof and other proceeds from the sale of military property shall be paid into the state treasury, and kept as a separate fund and are hereby appropriated for the improvement of the properties for military uses and shall be paid out upon proper vouchers approved by the adjutant general in accordance with the Act of Congress of the United States granting the lands, installations, or facilities to the state of North Dakota or as otherwise authorized by law.

The adjutant general, after consultation with the commissioner of insurance ~~commissioner~~, shall insure with the state fire and tornado fund in accordance with ~~the provisions of~~ chapter ~~26-24~~ 26.1-22 such buildings, installations, facilities or their contents or portions thereof as he shall in his discretion determine to be in the best interests of the state. The adjutant general shall not insure buildings or property that are subject to replacement by the United States.

* SECTION 26. AMENDMENT. Section 40-24-19 of the 1981 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

40-24-19. Warrants - Issuance - When payable - Amounts - Temporary warrants - Interest - Interest coupons - Negotiability - Eligibility as investments. The municipality, at any time after making a contract or otherwise providing in accordance with section 40-22-27 for the construction of any improvement to be financed in whole or in part by assessments, under authority of any chapter of this title, or prior thereto but after the period for filing protests against the making of such improvement has expired and the protests filed, if any, have been heard and determined to be insufficient, and in anticipation of the levy and collection of such assessments and of any taxes or revenues derived from service charges pledged to pay for such improvement, may issue warrants on the fund created for such improvement. The municipality ~~shall be~~ is responsible to the holders of ~~such~~ the warrants for the proper advertisement and award of a contract or contracts or provision by other means for the completion of the improvement, for the acquisition of all land, easements, licenses, and permits required for such completion, and for the valid and final levy of special assessments upon all properties within the improvement district to be benefited by the improvement, in an aggregate principal amount equal to the total cost of the improvement as finally ascertained, less the portions thereof, if any, determined to be paid from taxes, service charges, and any other source. The issuance of the warrants ~~shall constitute~~ constitutes a representation and covenant binding upon the municipality, that the aggregate benefits to be derived from the

* NOTE: Section 40-24-19 was also amended by section 6 of Senate Bill No. 2210, chapter 460.

making of the improvement by the properties to be assessed therefor, are not less than the aggregate amount of the special assessments so required to be levied. The warrants shall be issued and shall mature in such amounts as in the judgment of the governing body will be provided for, at or before the maturity dates specified, by the taxes and assessments to be levied and spread and the revenues pledged therefor. In lieu of issuing definitive warrants on any such fund, the governing body may by resolution authorize the issuance and sale of temporary warrants maturing in not to exceed three years from the date of issue of the first such warrant, to be repaid with interest from the proceeds of definitive warrants maturing as hereinabove required, which the governing body shall issue and sell at or before the maturing date of said temporary warrants, in the amount required, with moneys theretofore received in such fund, to pay the total cost of the improvement and all temporary warrants theretofore issued on the fund, with interest then accrued thereon. The warrants ~~shall~~ must bear interest at a rate or rates and ~~shall~~ must be sold at a price, not less than ninety-eight percent of par, resulting in an average net interest cost not to exceed twelve percent per annum payable annually or semiannually, except that there is no interest rate ceiling on an issue sold at public sale or to the state of North Dakota or any of its agencies or instrumentalities. The definitive warrants may bear interest at a rate or rates higher or lower than those borne by the temporary warrants, as determined by the governing body in effecting the sale thereof. In the sale of temporary warrants, the municipality may by resolution of the governing body agree to issue to the holder or holders thereof definitive warrants upon specified terms as to interest, maturity, redemption provisions, and all other pertinent details, in the event that the municipality is unable to sell definitive warrants to others upon more favorable terms. Coupons representing the interest for each year or lesser period may be attached to the warrants, whether definitive or temporary. All such warrants shall be negotiable within the meaning of and for all the purposes specified in title 41, and, to the same extent as general obligation bonds of the issuing municipality, ~~shall be~~ are valid investments of the funds of any guardian, trustee, and other fiduciary of any kind or nature, any ~~insurance company,~~ bank, or other financial institution, any charitable, educational, or eleemosynary institution, and any public corporation or official, municipality, school district, or other political subdivision, including bond sinking funds, special improvement funds, municipal utility funds, and funds of the state of North Dakota and its instrumentalities and agencies.

SECTION 27. AMENDMENT. Section 40-33.2-10 of the 1981 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

40-33.2-10. Authorized investments - Security for public deposits. Notwithstanding any other law to the contrary, the state of North Dakota and all its public officers, governmental units, agencies, and instrumentalities, all banks, trust companies, savings and loan associations, investment companies, credit unions, and other persons

carrying on a banking business, ~~all insurance companies, insurance associations, and other persons carrying on an insurance business,~~ and all executors, administrators, guardians, trustees, and other fiduciaries, and the Bank of North Dakota, may legally invest any sinking funds, money, or other funds belonging to them or within their control in any bonds or notes issued pursuant to this chapter.

SECTION 28. AMENDMENT. Section 40-38.1-07 of the 1981 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

40-38.1-07. Donations - How accepted - Council as trustee. All persons desirous of making donations of money, personal property, or real estate for the municipal arts fund may vest the same in the municipal arts council. The council shall hold and control all property accepted as a special trustee. The city auditor shall be ex officio treasurer of the council as such special trustee, and shall, under the direction of the council, keep, invest, and disburse all funds and securities so vested in said board. The treasurer shall be deemed a public employee and as such bonded through the state bonding fund in the amount fixed by the council and at the expense of the council, as are other public employees under ~~the provisions of~~ chapter ~~26-23~~ 26.1-21.

SECTION 29. AMENDMENT. Section 40-58-11 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

40-58-11. Bonds as legal investments. All banks, trust companies, bankers, savings banks and institutions, ~~building and loan associations,~~ savings and loan associations, investment companies and other persons carrying on a banking or investment business; ~~all insurance companies, insurance associations, and other persons carrying on an insurance business,~~ and all executors, administrators, curators, trustees, and other fiduciaries, may legally invest any sinking funds, moneys, or other funds belonging to them or within their control in any bonds or other obligations issued by a municipality pursuant to this chapter or by any urban renewal agency or housing authority vested with urban renewal project powers under section 40-58-15. ~~Provided, that such.~~ However, the bonds and other obligations ~~shall~~ must be secured by an agreement between the issuer and the federal government in which the issuer agrees to borrow from the federal government and the federal government agrees to lend to the issuer, prior to the maturity of ~~such~~ the bonds or other obligations, moneys in an amount which together with any other moneys irrevocably committed to the payment of interest on ~~such~~ the bonds or other obligations will suffice to pay the principal of such bonds or other obligations with interest to maturity thereon, which moneys under the terms of ~~said~~ the agreement are required to be used for the purpose of paying the principal of and the interest on ~~such~~ the bonds or other obligations at their maturity. ~~Such~~ The bonds and other obligations ~~shall be~~ are authorized security for all public deposits. ~~It is the purpose of this section to authorize any persons, political subdivisions and officers, public or private, to use any funds owned or controlled by~~

~~them for the purchase of any such bonds or other obligations. Nothing contained in this~~ This section ~~with regard to legal investments shall be construed as relieving~~ does not relieve any person of any duty of exercising reasonable care in selecting securities.

SECTION 30. AMENDMENT. Section 40-61-13 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

40-61-13. Bonds legal investments for public officers. Except as otherwise provided in the Constitution of ~~this state~~ North Dakota, the bonds are hereby made securities in which all public officers and bodies of this state and all municipalities and municipal subdivisions, ~~all insurance companies and associations and other persons carrying on an insurance business,~~ all banks, bankers, trust companies, savings banks, savings associations, including savings and loan associations, ~~building and loan associations,~~ investment companies, and other persons carrying on a banking business, and all other persons whatsoever except as hereinafter provided, who are now or may hereafter be authorized to invest in bonds or other obligations of the state, may properly and legally invest funds including capital in their control or belonging to them; ~~provided that~~. However, notwithstanding the provisions of any other general or special law to the contrary, ~~such~~ the bonds ~~shall~~ are not ~~be~~ eligible for the investment of funds, including capital, of trusts, estates, or guardianships under the control of individual administrators, guardians, executors, trustees, and other individual fiduciaries. The bonds are ~~also hereby made~~ authorized securities which may be deposited with and shall be received by all public officers and bodies of this state and all municipalities and municipal subdivisions for any purpose for which the deposit of bonds or other obligations of this state is now or may hereafter be authorized.

SECTION 31. AMENDMENT. Section 43-13-31 of the 1981 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

43-13-31. Discrimination in optometric services prohibited. ~~No~~ A person ~~shall~~ may not discriminate between licensed practitioners of optometry and physicians, or interfere with any individual's right to free choice of ocular practitioner, with respect to the providing of professional services within the scope of section 43-13-01. If a group health, accident or disability policy or contract of insurance, or any other type of employee group benefit or safety program specifically provides for the payment of optometric services within the scope of section 43-13-01, the payment ~~shall~~ must be made regardless of whether the service is performed by a physician or optometrist. ~~The provisions of this~~ This section ~~shall~~ does not apply to medical service contracts written by nonprofit ~~medical~~ health service corporations ~~or plans as set forth in chapter 26-27~~.

SECTION 32. AMENDMENT. Section 54-52-09 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

54-52-09. Exemption from state premium tax. Premiums, consideration for annuities, and membership fees ~~shall be construed as being~~ are exempt from premium taxes payable pursuant to section ~~26-01-11~~ 26.1-03-17.

* **SECTION 33. AMENDMENT.** Subsection 5 of section 54-52.1-01 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

5. "Health maintenance organization" means an organization certified to establish and operate a health maintenance organization in compliance with chapter ~~26-38~~ 26.1-18.

SECTION 34. AMENDMENT. Section 54-52.1-10 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

54-52.1-10. Exemption from state premium tax. All premiums, consideration for annuities, policy fees, and membership fees collected under ~~the provisions of~~ this chapter~~,~~ ~~shall be~~ are exempt from the tax payable pursuant to section ~~26-01-11~~ 26.1-03-17.

SECTION 35. AMENDMENT. Section 61-02-68.13 of the 1981 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

61-02-68.13. Interim financing notes as legal investments and security. Notwithstanding any restrictions contained in any other law, this state and all public officers, boards and agencies, and political subdivisions and agencies thereof, all national banking associations, state banks, trust companies, savings banks and institutions, ~~building and loan associations,~~ savings and loan associations, investment companies, and other persons carrying on a banking business, ~~all insurance companies, insurance associations and other persons carrying on an insurance business,~~ and all executors, administrators, guardians, trustees, and other fiduciaries, may legally invest any sinking funds, moneys, or other funds belonging to them or within their control in any interim financing notes issued by the commission pursuant to this chapter, and ~~such~~ the notes ~~shall be~~ are authorized security for any and all public deposits.

** **SECTION 36. AMENDMENT.** Section 61-02-72 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

61-02-72. Revenue bonds of commission are legal and valid investments of financial institutions. Revenue bonds regularly and legally issued by the commission are valid investments of the funds of any bank, trust company, ~~insurance company,~~ investment company, ~~building~~ savings and loan association, or similar financial institution.

Approved March 15, 1983

* NOTE: Section 54-52.1-01 was also amended by section 1 of Senate Bill No. 2093, chapter 580.

** NOTE: Section 61-02-72 was also amended by section 37 of Senate Bill No. 2234, chapter 676.

CHAPTER 320

SENATE BILL NO. 2271
(Lips)

HEALTH INSURANCE AND HMO DUAL CHOICE OPTION

AN ACT to provide minimum conditions for a dual choice option between nonprofit health service corporations or insurance companies and health maintenance organizations; to determine the payment of benefits for persons with continuous coverage; to amend and reenact section 26.1-02-20 of the North Dakota Century Code, relating to reinsurance; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. Dual choice option - Minimum conditions - Transfer of coverage. If an existing or prospective employer group desires a dual choice option between a nonprofit health service corporation or an insurance company and a health maintenance organization, the dual choice option may be made available to the employees in the group only if all of the following conditions are met:

1. There are at least fifteen employees in the group.

2. The group must maintain the highest enrollment percentage as specified in the underwriting manual of the nonprofit health service corporation, the insurance company, or the health maintenance organization, and the health maintenance organization enrollees must be combined with subscribers of nonprofit health service corporations or insureds of insurance companies in meeting the percentage requirements.

3. An employee must be allowed to transfer between coverage offered by a health maintenance organization and coverage offered by a nonprofit health service organization or insurance company on the group's anniversary date as specified in the master contract with the group, except a special opening must be offered at the group's request for the following reasons:

a. Upon a group's initial offering of a dual choice plan in addition to existing coverages offered by a nonprofit health service corporation or an insurance company.

b. When a group discontinues offering a dual choice plan with a health maintenance organization to request open enrollment into the group offered by the nonprofit health service corporation or the insurance company.

c. If the group offers both coverage by a nonprofit health service corporation or an insurance company and a health maintenance organization and an individual employee enrolled in the health maintenance organization transfers within the same company but leaves the service area of the health maintenance organization, the employee must be allowed to enroll in the plan offered by the nonprofit health service corporation or the insurance company at the time of transfer.

d. Any group which offers health coverage to its retired employees by a nonprofit health service corporation or an insurance company and a health maintenance organization must advise the employees who are enrolled under their present coverage that they may change to other coverage offered at the time of retirement and if the employees who retire elect to retain or change their present coverage, the employees will no longer be eligible to change coverage after retirement.

SECTION 2. Continuous coverage - Payment of benefits. If an employee, or an eligible dependent of the employee, transfers from coverage provided by a nonprofit health service corporation or an insurance company to coverage offered by a health maintenance organization or transfers from coverage offered by a health maintenance organization to coverage offered by a nonprofit health service corporation or an insurance company and is an inpatient of a hospital or alcoholism treatment center on the day the coverage becomes effective, then the benefits for confinement on an inpatient basis of a hospital or alcoholism treatment center must be provided by the nonprofit health service corporation, insurance company, or health maintenance organization providing coverage on the date the employee or the eligible dependent of the employee was confined as an inpatient of a hospital or alcoholism treatment center so long as coverage is uninterrupted, medically necessary, and directly related to the inpatient's stay.

SECTION 3. AMENDMENT. Section 26.1-02-20 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-02-20. Reinsurance permitted - Limitations. Except as otherwise provided by this section and section 26.1-02-22, any insurance company organized or admitted to transact business in this state, including a mutual company, may reinsure any part or all of any risk taken by it in any insurance company or insurer licensed in any state or any insurance company or insurer not so licensed provided it was approved or accepted by the commissioner, if that company or insurer conforms to the same standards of solvency which would be required if, at the time the reinsurance is effected, it was licensed in this state. ~~An insurance company organized or admitted to transact business in this state may reinsure a part or all of any risk taken by it in an insurance company or insurer not licensed in any state, if it is approved or accepted by the commissioner.~~ A county mutual insurance company also may reinsure with any other county mutual insurance company. No reinsurance, however, may be effected with any company disapproved therefor by written order of the commissioner filed in the commissioner's office. A domestic insurance company organized to engage in the business of life, accident, or health insurance may not reinsure its risks or any part thereof without complying with chapter 26.1-07.

SECTION 4. EMERGENCY. This Act is hereby declared to be an emergency measure and is in effect from and after its passage and approval.

Approved April 11, 1983

CHAPTER 321

HOUSE BILL NO. 1322
(Rued)

HAIL INSURANCE POLICY INCEPTION

AN ACT to amend and reenact section 26-03-49 of the North Dakota Century Code, relating to the inception and expiration of policies of insurance.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26-03-49 of the 1981 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-03-49. Inception and expiration of policies - Inception of hail insurance policies. Policies of insurance shall cover the insured at 12:01 a.m. on the day on which coverage begins and shall expire at 12:01 a.m. on the day of expiration of such policy. However, policies of insurance on growing crops against loss by hail take effect at the time and on the day stated on the application for the insurance. The provision allowing policies of insurance on growing crops against loss by hail to take effect as provided on the application may not be limited or restricted by rule or bulletin of the commissioner of insurance.

Approved March 7, 1983

CHAPTER 322

SENATE BILL NO. 2252
(Committee on Industry, Business, and Labor)
(At the request of the Commissioner of Insurance)

LIFE INSURANCE NONFORFEITURE

AN ACT to create and enact sections 26-03.2-06.1, 26-03.2-06.2, and 26-03.2-07.1, relating to the nonforfeiture law for life insurance; and to amend and reenact sections 26-03.2-01, 26-03.2-02, 26-03.2-04, 26-03.2-05, 26-03.2-06, 26-03.2-07, and 26-03.2-08 of the North Dakota Century Code, relating to the nonforfeiture law for life insurance.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26-03.2-01 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-03.2-01. Required provisions relating to lapsing policyholder. In the case of policies issued prior to the operative date of this chapter, the options on surrender or lapse or the provisions for continuance of insurance in the event of lapse shall be as provided in sections 26-03-26, 26-03-27, 26-03-28, 26-03-29, 26-03-30, 26-03-31, and 26-03-35. In the case of policies issued on and after the operative date of this chapter, no policy of life insurance, except as stated in section 26-03.2-08, shall be delivered or issued for delivery in this state unless it shall contain in substance the following provisions, or corresponding provisions which in the opinion of the commissioner are at least as favorable to the defaulting or surrendering policyholder as are the minimum requirements hereinafter specified and are essentially in compliance with section 26-03.2-07.1:

1. In the event of default in any premium payment, the company will grant, upon proper request not later than sixty days after the due date of the premium in default, a paid-up nonforfeiture benefit on a plan stipulated in the policy, effective as of such due date, of such ~~value~~ amount as may be hereinafter specified. In lieu of such stipulated paid-up nonforfeiture benefit, the company may substitute, upon proper request not later than sixty days after the due date of the premium in default, an

actuarially equivalent alternative paid-up nonforfeiture benefit which provides a greater amount or longer period of death benefits or, if applicable, a greater amount or earlier payment of endowment benefits.

2. Upon surrender of the policy within sixty days after the due date of any premium payment in default after premiums have been paid for at least three full years in the case of ordinary insurance or five full years in the case of industrial insurance, the company will pay, in lieu of any paid-up nonforfeiture benefit, a cash surrender value of such amount as may be hereinafter specified.

3. A specified paid-up nonforfeiture benefit shall become effective as specified in the policy unless the person entitled to make such election elects another available option not later than sixty days after the due date of the premium in default.

4. If the policy shall have become paid-up by completion of all premium payments or if it is continued under any paid-up nonforfeiture benefit which became effective on or after the third policy anniversary in the case of ordinary insurance or the fifth policy anniversary in the case of industrial insurance, then the company will pay, upon surrender of the policy within thirty days after any policy anniversary, a cash surrender value of such amount as may be hereinafter specified.

5. A In the case of policies which cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than a change to a new policy, a statement of the mortality table, interest rate, and method used in calculating cash surrender values and the paid-up nonforfeiture benefits available under the policy. In the case of all other policies, a statement of the mortality table and interest rate or rates used in calculating the cash surrender values and the paid-up nonforfeiture benefits available under the policy, together with a table showing the cash surrender value, if any, and paid-up nonforfeiture benefit, if any, available under the policy on each policy anniversary either during the first twenty policy years or during the term of the policy, whichever is shorter, such values and benefits to be calculated upon the assumption that there are no dividends or paid-up additions credited to the policy and that there is no indebtedness to the company on the policy.

6. A statement that the cash surrender values and the paid-up nonforfeiture benefits available under the policy are not less than the minimum values and benefits required by or pursuant to the insurance law of the state in which the

policy is delivered; an explanation of the manner in which the cash surrender values and the paid-up nonforfeiture benefits are altered by the existence of any paid-up additions credited to the policy or any indebtedness to the company on the policy; if a detailed statement of the method of computation of the values and benefits shown in the policy is not stated therein, a statement that such method of computation has been filed with the insurance supervisory official of the state in which the policy is delivered; and a statement of the method to be used in calculating the cash surrender value and paid-up nonforfeiture benefit available under the policy on any policy anniversary beyond the last anniversary for which such values and benefits are consecutively shown in the policy.

Any of the foregoing provisions or portions thereof not applicable by reason of the plan of insurance may, to the extent inapplicable, be omitted from the policy.

The company shall reserve the right to defer the payment of any cash surrender value for a period of six months after demand therefor with surrender of the policy.

SECTION 2. AMENDMENT. Section 26-03.2-02 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-03.2-02. Minimum cash surrender value.

1. Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary, whether or not required by section 26-03.2-01, shall be an amount not less than the excess, if any, of the present value, on such anniversary, of the future guaranteed benefits which would have been provided by the policy, including any existing paid-up additions, if there had been no default, over the sum of ~~(1)~~ (a) the then present value of the adjusted premiums as defined in sections 26-03.2-04, 26-03.2-05, ~~and~~ 26-03.2-06, and 26-03.2-06.1 corresponding to premiums which would have fallen due on and after such anniversary, and ~~(2)~~ (b) the amount of any indebtedness to the company on the policy.

2. Any policy issued on or after the operative date of section 26-03.2-06.1 as defined therein, which provides supplemental life insurance or annuity benefits at the option of the insured and for an identifiable additional premium by rider or supplemental policy provision, the cash surrender value referred to in subsection 1 shall be an amount not less than the sum of the cash surrender value as defined in that subsection for an otherwise similar policy issued at the same age without such rider or supplemental policy provision and the cash surrender

value as defined in that subsection for a policy which provides only the benefits otherwise provided by such rider or supplemental policy provision.

3. For any family policy issued on or after the operative date of section 26-03.2-06.1 as defined therein, which defines a primary insured and provides term insurance on the life of the spouse of the primary insured expiring before the spouse's age seventy-one, the cash surrender value referred to in subsection 1 shall be an amount not less than the sum of the cash surrender value as defined in that subsection for an otherwise similar policy issued at the same age without such term insurance on the life of the spouse and the cash surrender value as defined in that subsection for a policy which provides only the benefits otherwise provided by such term insurance on the life of the spouse.

4. Any cash surrender value available within thirty days after any policy anniversary under any policy paid-up by completion of all premium payments or any policy continued under any paid-up nonforfeiture benefit, whether or not required by section 26-03.2-01, shall be an amount not less than the present value, on such anniversary, of the future guaranteed benefits provided for by the policy, including any existing paid-up additions, decreased by any indebtedness to the company on the policy.

SECTION 3. AMENDMENT. Section 26-03.2-04 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-03.2-04. Definition of adjusted premiums used in obtaining minimum cash surrender value.

1. This section does not apply to policies issued on or after the operative date of section 26-03.2-06.1 as defined therein. Except as provided in subsection 3, the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding amounts stated in the policy as extra premiums to cover impairments or special hazards, that the present value, at the date of issue of the policy, of all such adjusted premiums shall be equal to the sum of:

   a. The then present value of the future guaranteed benefits provided by the policy.

   b. Two percent of the amount of insurance, if the insurance be uniform in amount, or of the equivalent uniform amount, as hereinafter defined, if the amount of insurance varies with duration of the policy.

c. Forty percent of the adjusted premium for the first policy year.

d. Twenty-five percent of either the adjusted premium for the first policy year or the adjusted premium for a whole life policy of the same uniform or equivalent uniform amount with uniform premiums for the whole of life issued at the same age for the same amount of insurance, whichever is less.

Provided, however, that in applying the percentages specified in subdivisions c and d, no adjusted premium shall be deemed to exceed four percent of the amount of insurance or equivalent uniform amount. The date of issue of a policy for the purpose of this section shall be the date as of which the rated age of the insured is determined.

2. In the case of a policy providing an amount of insurance varying with duration of the policy, the equivalent uniform amount thereof for the purpose of this section shall be deemed to be the level amount of insurance provided by an otherwise similar policy, containing the same endowment benefit or benefits, if any, issued at the same age and for the same term, the amount of which does not vary with duration and the benefits under which have the same present value at the date of issue of the policy as do the benefits under the policy.

3. The adjusted premiums for any policy providing term insurance benefits by rider or supplemental policy provision shall be equal to (a) the adjusted premiums for an otherwise similar policy issued at the same age without such term insurance benefits, increased, during the period for which premiums for such term insurance benefits are payable, by (b) the adjusted premiums for such term insurance, the foregoing items (a) and (b) being calculated separately and as specified in subsections 1 and 2 except that, for the purposes of subdivisions b, c, and d of subsection 1, the amount of insurance or equivalent uniform amount of insurance used in the calculation of the adjusted premiums referred to in (b) shall be equal to the excess of the corresponding amount determined for the entire policy over the amount used in the calculation of the adjusted premiums in (a).

SECTION 4. AMENDMENT. Section 26-03.2-05 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-03.2-05. Mortality and interest bases for adjusted premiums and present values - Ordinary insurance. This section does not apply to ordinary policies issued on or after the operative date of section 26-03.2-06.1 as defined therein. In the case of ordinary policies,

all adjusted premiums and present values referred to in this chapter shall be calculated on the basis of the commissioners' 1958 standard ordinary mortality table and the rate or rates of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits provided that no such rate of interest shall exceed five and one-half percent per year, except that for any single premium whole life or endowment insurance policy a rate of interest not exceeding six and one-half percent per year may be used, and provided that for any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age not more than six years younger than the actual age of the insured. Provided, however, that in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not greater than those shown in the commissioners' 1958 extended term insurance table. Provided, further, that for insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the company and approved by the commissioner.

SECTION 5. AMENDMENT. Section 26-03.2-06 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-03.2-06. Mortality and interest bases for adjusted premiums and present values - Industrial insurance. This section does not apply to industrial policies issued on or after the operative date of section 26-03.2-06.1 as defined therein. In the case of industrial policies, all adjusted premiums and present values referred to in this chapter shall be calculated on the basis of the commissioners' 1961 standard industrial mortality table and the rate or rates of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits provided that no such rate of interest shall exceed five and one-half percent per year, except that for any single premium whole life or endowment insurance policy a rate of interest not exceeding six and one-half percent per year may be used. Provided, however, that in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not greater than those shown in the commissioners' 1961 industrial extended term insurance table. Provided, further, that for insurance issued on a substandard basis, the calculations of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the company and approved by the commissioner.

SECTION 6. Section 26-03.2-06.1 to the North Dakota Century Code is hereby created and enacted to read as follows:

26-03.2-06.1. Determination of minimum values.

1. This section applies to all policies issued on or after the operative date of this section as defined herein,

except as provided in subsection 7, the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments or special hazards and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the date of issue of the policy, of all adjusted premiums shall be equal to the sum of:

a. The then present value of the future guaranteed benefits provided for by the policy;

b. One percent of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years; and

c. One hundred twenty-five percent of the nonforfeiture net level premium as hereinafter defined.

However, in applying the percentage specified in subdivision c, no nonforfeiture net level premium may exceed four percent of either the amount of insurance, if the insurance is uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years. The date of issue of a policy for the purpose of this section is the date as of which the rated age of the insured is determined.

2. The nonforfeiture net level premium is equal to the present value, at the date of issue of the policy, of the guaranteed benefits provided for by the policy divided by the present value, at the date of issue of the policy, of an annuity of one per annum payable on the date of issue of the policy and on each anniversary of such policy on which a premium falls due.

3. In the case of policies which cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than a change to a new policy, the adjusted premiums and present values shall initially be calculated on the assumption that future benefits and premiums do not change from those stipulated at the date of issue of the policy. At the time of any such change in the benefits or premiums the future adjusted premiums, nonforfeiture net level premiums and present values shall be recalculated on the assumption that future benefits and premiums do not change from those stipulated by the policy immediately after the change.

4. Except as otherwise provided in subsection 7, the recalculated future adjusted premiums for any such policy shall be such uniform percentage of the respective future premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments and special hazards, and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the time of change to the newly defined benefits or premiums, of all such future adjusted premiums equals the excess of (a) the sum of the then present value of the then future guaranteed benefits provided for by the policy, and the additional expense allowance, if any, over (b) the then cash surrender value, if any, or present value of any paid-up nonforfeiture benefit under the policy.

5. The additional expense allowance, at the time of the change to the newly defined benefits or premiums, is the sum of (a) one percent of the excess, if positive, of the average amount of insurance at the beginning of each of the first ten policy years subsequent to the change over the average amount of insurance prior to the change at the beginning of each of the first ten policy years subsequent to the time of the most recent previous change, or, if there has been no previous change, the date of issue of the policy; and (b) one hundred twenty-five percent of the increase, if positive, in the nonforfeiture net level premium.

6. The recalculated nonforfeiture net level premium is equal to the result obtained by dividing the sum of:

   a. The nonforfeiture net level premium applicable prior to the change times the present value of an annuity of one per annum payable on each anniversary of the policy on or subsequent to the date of the change on which a premium would have fallen due had the change not occurred; and

   b. The present value of the increase in future guaranteed benefits provided for by the policy; by

   c. The present value of an annuity of one per annum payable on each anniversary of the policy on or subsequent to the date of change on which a premium falls due.

7. Notwithstanding any other provisions of this section to the contrary, in the case of a policy issued on a substandard basis which provides reduced graded amounts of insurance so that, in each policy year, the policy has the same tabular mortality cost as an otherwise similar policy

issued on the standard basis which provides higher uniform amounts of insurance, adjusted premiums and present values for such substandard policy may be calculated as if it were issued to provide such higher uniform amounts of insurance on the standard basis.

8. All adjusted premiums and present values referred to in this Act shall for all policies of ordinary insurance be calculated on the basis of (a) the commissioners 1980 standard ordinary mortality table, or (b) at the election of the company for any one or more specified plans of life insurance, the commissioners 1980 standard ordinary mortality table with ten-year select mortality factors; shall for all policies of industrial insurance be calculated on the basis of the commissioners 1961 standard industrial mortality table; and shall for all policies issued in a particular calendar year be calculated on the basis of a rate of interest not exceeding the nonforfeiture interest rate as defined in this section for policies issued in that calendar year. However:

   a. At the option of the company, calculations for all policies issued in a particular calendar year may be made on the basis of a rate of interest not exceeding the nonforfeiture interest rate, as defined in this section, for policies issued in the immediately preceding calendar year.

   b. Under any paid-up nonforfeiture benefit, including any paid-up dividend additions, any cash surrender value available, whether or not required by section 26-03.2-01, shall be calculated on the basis of the mortality table and rate of interest used in determining the amount of such paid-up nonforfeiture benefit and paid-up dividend additions, if any.

   c. A company may calculate the amount of any guaranteed paid-up nonforfeiture benefit including any paid-up additions under the policy on the basis of an interest rate no lower than that specified in the policy for calculating cash surrender values.

   d. In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the commissioners 1980 extended term insurance table for policies of ordinary insurance and not more than the commissioners 1961 industrial extended term insurance table for policies of industrial insurance.

   e. For insurance issued on a substandard basis, the calculation of any such adjusted premiums and present

values may be based on appropriate modifications of the tables.

f. Any ordinary mortality tables, adopted after 1980 by the national association of insurance commissioners, that are approved by rule adopted by the commissioner for use in determining the minimum nonforfeiture standard may be substituted for the commissioners 1980 standard ordinary mortality table with or without ten-year select mortality factors or for the commissioners 1980 extended term insurance table.

g. Any industrial mortality tables, adopted after 1980 by the national association of insurance commissioners, that are approved by rule adopted by the commissioner for use in determining the minimum nonforfeiture standard may be substituted for the commissioners 1961 standard industrial mortality table or the commissioners 1961 industrial extended term insurance table.

9. The nonforfeiture interest rate per annum for any policy issued in a particular calendar year shall be equal to one hundred twenty-five percent of the calendar year statutory valuation interest rate for such policy as defined in the Standard Valuation Law, rounded to the nearer one quarter of one percent.

10. Notwithstanding any other provision in this code to the contrary, any refiling of nonforfeiture values or their methods of computation for any previously approved policy form which involves only a change in the interest rate or mortality table used to compute nonforfeiture values shall not require refiling of any other provisions of that policy form.

11. After the effective date of this section any company may file with the commissioner a written notice of its election to comply with the provisions of this section after a specified date before January 1, 1989, which shall be the operative date of this section for such company. If a company makes no such election, the operative date of this section for such company shall be January 1, 1989.

SECTION 7. Section 26-03.2-06.2 to the North Dakota Century Code is hereby created and enacted to read as follows:

26-03.2-06.2. Determination of minimum value of policies with future premium determination-in-determinable value. In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurance company based on then estimates of future experience, or in the case of any plan of life insurance which is of such a nature

that minimum values cannot be determined by the methods described in sections 26-03.2-01 through 26-03.2-06.1, then:

1. The commissioner must be satisfied that the benefits provided under the plan are substantially as favorable to policyholders and insureds as the minimum benefits otherwise required by sections 26-03.2-01 through 26-03.2-06.1;

2. The commissioner must be satisfied that the benefits and the pattern of premiums of that plan are not such as to mislead prospective policyholders or insureds; and

3. The cash surrender values and paid-up nonforfeiture benefits provided by such plan must not be less than the minimum values and benefits required for the plan computed by a method consistent with the principles of this Standard Nonforfeiture Law for Life Insurance, as determined by rules adopted by the commissioner.

SECTION 8. AMENDMENT. Section 26-03.2-07 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-03.2-07. Benefits on default off the anniversary, benefits exempted from chapter. Any cash surrender value and any paid-up nonforfeiture benefit, available under the policy in the event of default in a premium payment due at any time other than on the policy anniversary, shall be calculated with allowance for the lapse of time and the payment of fractional premiums beyond the last preceding policy anniversary. All values referred to in sections 26-03.2-02, 26-03.2-03, 26-03.2-04, 26-03.2-05, ~~and~~ 26-03.2-06, and 26-03.2-06.1 may be calculated upon the assumption that any death benefit is payable at the end of the policy year of death. The net value of any paid-up additions, other than paid-up term additions, shall be not less than the ~~dividends~~ amounts used to provide such additions. Notwithstanding the provisions of section 26-03.2-02, additional benefits payable (1) in the event of death or dismemberment by accident or accidental means; (2) in the event of total and permanent disability; (3) as reversionary annuity or deferred reversionary annuity benefits; (4) as ~~decreasing~~ term insurance benefits provided by a rider or supplemental policy provision to which, if issued as a separate policy, this chapter would not apply; (5) as term insurance on the life of a child or on the lives of children provided in a policy on the life of a parent of the child, if such term insurance expires before the child's age is twenty-six years, is uniform in amount after the child's age is one year, and has not become paid-up by reason of the death of a parent of the child; and (6) as other policy benefits additional to life insurance and endowment benefits, and premiums for all such additional benefits, shall be disregarded in ascertaining cash surrender values and nonforfeiture benefits required by this chapter, and no such additional benefits shall be required to be included in any paid-up nonforfeiture benefits.

SECTION 9. Section 26-03.2-07.1 to the North Dakota Century Code is hereby created and enacted to read as follows:

26-03.2-07.1. Determination of minimum values after January 1, 1987.

1. This section, in addition to all other applicable sections of this Act, applies to all policies issued on or after January 1, 1987. Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary shall be in an amount which does not differ by more than two-tenths of one percent of either the amount of insurance, if the insurance is uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years, from the sum of (a) the greater of zero and the basic cash value hereinafter specified and (b) the present value of any existing paid-up additions less the amount of any indebtedness to the company under the policy.

2. The basic cash value is equal to the present value, on such anniversary, of the future guaranteed benefits which would have been provided for by the policy, excluding any existing paid-up additions and before deduction of any indebtedness to the company, if there had been no default, less the then present value of the nonforfeiture factors, as hereinafter defined, corresponding to premiums which would have fallen due on and after such anniversary. However, the effects on the basic cash value of supplemental life insurance or annuity benefits or of family coverage, as described in section 26-03.2-02 and 26-03.2-04, whichever is applicable, shall be the same as are the effects specified in section 26-03.2-02 or 26-03.2-04, whichever is applicable, on the cash surrender values defined in that section.

3. The nonforfeiture factor for each policy year is an amount equal to a percentage of the adjusted premium for the policy year, as defined in section 26-03.2-04 or 26-03.2-06.1, whichever is applicable. Except as is required by subsection 4, the percentage:

   a. Must be the same percentage for each policy year between the second policy anniversary and the later of the fifth policy anniversary and the first policy anniversary at which there is available under the policy a cash surrender value in an amount, before including any paid-up additions and before deducting any indebtedness, of at least two-tenths of one percent of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten policy years; and

b. Must be such that no percentage after the later of the two policy anniversaries specified in subdivision a may apply to fewer than five consecutive policy years.

4. No basic cash value may be less than the value which would be obtained if the adjusted premiums for the policy, as defined in section 26-03.2-04 or 26-03.2-06.1, whichever is applicable, were substituted for the nonforfeiture factors in the calculation of the basic cash value.

5. All adjusted premiums and present values referred to in this section shall for a particular policy be calculated on the same mortality and interest bases as are used in demonstrating the policy's compliance with the other sections of this Act. The cash surrender values referred to in this section shall include any endowment benefits provided for by the policy.

6. Any cash surrender value available other than in the event of default in a premium payment due on a policy anniversary, and the amount of any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment shall be determined in manners consistent with the manners specified for determining the analogous minimum amounts in sections 26-03.2-01, 26-03.2-02, 26-03.2-03, 26-03.2-06.1, and 26-03.2-07. The amounts of any cash surrender values and of any paid-up nonforfeiture benefits granted in connection with additional benefits such as those listed as items (1) through (6) in section 26-03.2-07 shall conform with the principles of this section.

SECTION 10. AMENDMENT. Section 26-03.2-08 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-03.2-08. Exemptions from chapter. This chapter shall not apply to any ~~reinsurance, group insurance, pure endowment, annuity~~ of the following:

1. Reinsurance;

2. Group insurance;

3. Pure endowment;

4. Annuity or reversionary annuity contract~~, nor to any term~~;

5. Term policy of uniform amount, which provides no guaranteed nonforfeiture or endowment benefits, or renewal thereof, of ~~fifteen~~ twenty years or less expiring before age ~~sixty-six~~ seventy-one, for which uniform premiums are payable during the entire term of the policy, ~~nor to any term policy~~;

6. Policy of decreasing amount, which provides no guaranteed nonforfeiture or endowment benefits, on which each adjusted premium, calculated as specified in sections 26-03.2-04, 26-03.2-05, ~~and~~ 26-03.2-06, and 26-03.2-06.1 is less than the adjusted premium so calculated on ~~such fifteen-year~~ a term policy of uniform amount, or renewal thereof, which provides no guaranteed nonforfeiture or endowment benefits, issued at the same age and for the same initial amount of insurance~~,~~ and for a term of twenty years or less expiring before age seventy-one, for which uniform premiums are payable during the entire term of the policy;

7. Policy, which provides no guaranteed nonforfeiture or endowment benefits, for which no cash surrender value, if any, or present value of any paid-up nonforfeiture benefit, at the beginning of any policy year, calculated as specified in sections 26-03.2-02 through 26-03.2-06.1, exceeds two and one-half percent of the amount of insurance at the beginning of the same policy year; nor ~~to any policy~~

8. Policy which shall be delivered outside this state through an agent or other representative of the company issuing the policy.

For purposes of determining the applicability of this chapter, the age of expiry for a joint term life insurance policy shall be the age of expiry of the oldest life.

Approved March 4, 1983

CHAPTER 323

HOUSE BILL NO. 1583
(Peltier)

STANDARD POLICY PROVISIONS

AN ACT to provide for standard policy provisions through life and health insurance.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. **Group life insurance standard provision.** No policy of group life insurance may be delivered in this state unless it contains in substance the following provisions, or provisions which in the opinion of the commissioner are more favorable to the persons insured, or at least as favorable to the persons insured and more favorable to the policyholder; provided, however, that the standard provisions required for individual life insurance policies may not apply to group life insurance policies; and that if the group life insurance policy is on a plan of insurance other than the term plan, it shall contain a nonforfeiture provision or provisions which in the opinion of the commissioner is or are equitable to the insured persons and to the policyholder, but nothing herein shall be construed to require that group life insurance policies contain the same nonforfeiture provisions as are required for individual life insurance policies:

1. A provision that the policyholder is entitled to a grace period of thirty-one days for the payment of any premium due except the first, during which grace period the death benefit coverage shall continue in force, unless the policyholder shall have given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder shall be liable to the insurer for the payment of a pro rata premium for the time the policy was in force during such a grace period.

2. A provision that the validity of the policy shall not be contested except for nonpayment of premiums, after it has been in force for two years from its date of issue; and that no statement made by any person insured under the

policy relating to his insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two years during such person's lifetime nor unless it is contained in a written instrument signed by him; provided, however, that no such provision shall preclude the assertion of any time of defenses based upon provisions in the policy which relate to eligibility for coverage.

3. A provision that a copy of the application, if any, of the policyholder shall be attached to the policy when issued, that all statements made by the policyholder or by the persons insured shall be deemed representations and not warranties, and that no statement made by any person insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such person or, in the event of death or incapacity of the insured person, to his beneficiary or personal representative.

4. A provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of the individual's coverage.

5. A provision specifying an equitable adjustment of premiums or of benefits or of both to be made in the event the age of a person insured has been misstated, such provision to contain a clear statement of the method of adjustment to be made.

6. A provision that any sum becoming due by reason of the death of the person insured shall be payable to the beneficiary designated by the person insured, except that where the policy contains conditions pertaining to family status the beneficiary may be the family member specified by the policy terms, subject to the provisions of the policy in the event there is no designated beneficiary, as to all or any part of such sum, living at the death of the person insured and subject to any right reserved by the insurer in the policy and set forth in the certificate to pay at its option a part of such sum not exceeding five thousand dollars to any person appearing to the insurer to be equitably entitled thereto by reason of having incurred funeral or other expenses incident to the last illness or death of the person insured.

7. A provision that the insurer will issue to the policyholder for delivery to each person insured a certificate setting forth a statement as to the insurance protection to which that person is entitled, a statement as to any dependent's coverage included in such

certificate, and the rights and conditions set forth in subsections 8, 9, 10, and 11.

8. A provision that if the insurance, or any portion of it, on a person covered under the policy or on the dependent of a person covered, ceases because of termination of employment or of membership in the class or classes eligible for coverage under the policy, such person shall be entitled to have issued to him by the insurer, without evidence of insurability, an indidividual policy of life insurance without disability or other supplementary benefits, provided application for the individual policy shall be made, and the first premium paid to the insurer, within thirty-one days after such termination, and provided further that:

   a. The individual policy shall, at the option of such person, be on any one of the forms then customarily issued by the insurer at the age and for the amount applied for, except that the group policy may exclude the option to elect term insurance.

   b. The individual policy shall be in an amount not in excess of life insurance which ceases because of such termination, less the amount of life insurance for which such person becomes eligible under the same or any other group policy within thirty-one days after such termination, provided that any amount of insurance which shall have matured on or before the date of such termination as an endowment payable to the person insured, whether in one sum or in installments or in the form of an annuity, shall not, for purposes of this provision, be included in the amount which is considered to cease because of such termination; and

   c. The premium on the individual policy shall be at the insurer's then customary rate applicable to the form and amount of the individual policy, to the class of risk to which such person then belongs, and to the individual age attained on the effective date of the individual policy.

   Subject to the same conditions set forth above, the conversion privilege shall be available to a surviving dependent, if any, at the death of the employee or member, with respect to the coverage under the group policy which terminates by reason of such death and to the dependent of the employee or member upon termination of coverage of the dependent, while the employee or member remains under the group policy, by reason of the dependent ceasing to be a qualified family member under the group policy.

9. A provision that if the group policy terminates or is amended so as to terminate the insurance of any class of insured persons, every person insured thereunder at the date of such termination whose insurance terminates, including the insured dependent of a covered person, and who has been so insured for at least five years prior to such termination date shall be entitled to have issued by the insurer an individual policy of life insurance, subject to the same conditions and limitations as are provided by subsection 8, except that the group policy may provide that the amount of such individual policy shall not exceed the smaller of (a) the amount of the person's life insurance protection ceasing because of the termination or amendment of the group policy, less the amount of any life insurance for which he is or becomes eligible under a group policy issued or reinstated by the same or another insurer within thirty-one days after such termination, or (b) ten thousand dollars.

10. A provision that if a person insured under the group policy, or the insured dependent of a covered person, dies during the period within which the individual would have been entitled to have an individual policy issued in accordance with subsections 8 or 9 and before such an individual policy shall have become effective, the amount of life insurance which he would have been entitled to have issued under such individual policy shall be payable as a claim under the group policy, whether or not application for the individual policy or the payment of the first premium therefor has been made.

11. Where active employment is a condition of insurance, a provision that an insured may continue coverage during the insured's total disability by timely payment to the policyholder of that portion, if any, of the premium that would have been required from the insured had total disability not occurred. The continuation shall be on a premium paying basis for a period of six months from the date on which the total disability started, but not beyond the earlier of (a) approval by the insurer of continuation of the coverage under any disability provision which the group insurance policy may contain, or (b) the discontinuance of the group insurance policy.

SECTION 2. Conversion privileges. If any individual insured under a group life insurance policy hereafter delivered in this state becomes entitled under the terms of such policy to have an individual policy of life insurance issued without evidence of insurability, subject to making of application and payment of the first premium within the period specified in such policy, and if such individual is not given notice of the existence of such right at least fifteen days prior to the expiration date of such period, then in such event the individual shall have an additional period within which to exercise such right. This additional period shall

expire fifteen days next after the individual is given such notice. Written notice presented to the individual or mailed to the policyholder to the last known address of the individual or mailed by the insurer to the last known address of the individual as furnished by the policyholder or notice of the right of conversion included in a certificate provided to each employee or notice provided by the attachment of a separate notice to the certificate shall constitute notice for the purpose of this paragraph.

SECTION 3. Group health insurance standard provision. No policy of group health insurance may be delivered in this state unless it contains in substance the following provision, or provisions, which in the opinion of the commissioner are more favorable to the persons insured and more favorable to the policyholder, provided, however, that the standard provisions required for individual health insurance policies shall not apply to group health insurance policies; and that if any provision of this section 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 the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy:

1. A provision that the policyholder is entitled to a grace period of fifteen days for monthly premiums and thirty-one days for all others for the payment of any premium due except the first, during which grace period of the policy shall continue in force, unless the policyholder shall have given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder shall be liable to the insurer for the payment of a pro rata premium for the time the policy was in force during such grace period.

2. A provision that the validity of the policy shall not be contested except for nonpayment of premiums, after it has been in force for two years from its date of issue; and that the validity of the policy shall not be contested on the basis of a statement made relating to insurability by any person covered under the policy after such insurance has been in force for two years during such person's lifetime and shall not be contested unless the statement is contained in a written instrument signed by the person making such statement; provided, however, that no such provision shall preclude the assertion at any time of defenses based upon the person's ineligibility for coverage under the policy.

3. A provision that a copy of the application, if any, of the policyholder shall be attached to the policy when issued, that all statements made by the policyholder or by the

persons insured shall be deemed representations and not warranties, and that no statement made by any person insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such person or, in the event of the death or incapacity of the insured person, to the individual's beneficiary or personal representative.

4. A provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of the individual's coverage.

5. A provision specifying the additional exclusions or limitations, if any, applicable under the policy with respect to a disease or physical condition of a person, not otherwise excluded from the person's coverage by name or specific description effective on the date of the person's loss, which existed prior to the effective date of the person's coverage under the policy. Any such exclusion or limitation may only apply to a disease or physical condition for which medical advice or treatment was received by the person during the twelve months prior to the effective date of the person's coverage. In no event shall such exclusion or limitation apply to loss incurred or disability commencing after the earlier of the end of a continuance period of twelve months commencing on or after the effective date of the person's coverage during all of which the person has received no medical advice or treatment in connection with such disease or physical condition; and the end of the two-year period commencing on the effective date of the person's coverage.

6. If the premiums or benefits vary by age, there shall be a provision specifying an equitable adjustment of premiums or of benefits, or both, to be made in the event the age of a covered person has been misstated, such provision to contain a clear statement of the method of adjustment to be used.

7. A provision that the insurer will issue to the policyholder for delivery to each person insured a certificate setting forth a statement as to the insurance protection to which that person is entitled, to whom the insurance benefits are payable, and a statement as to any family member's or dependent's coverage.

8. A provision that written notice of claim must be given to the insurer within twenty days after the occurrence or commencement of any loss covered by the policy. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been

reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

9. A provision that the insurer will furnish to the person making claim, or to the policyholder for delivery to such person, such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of fifteen days after the insurer receives notice of any claim under the policy, the person making such claim shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character, and extent of the loss for which claims are made.

10. A provision that in the case of claim for loss of time for disability, written proof of such loss must be furnished to the insurer within ninety days after the commencement of the period for which the insurer is liable, and that subsequent written proof of the continuance of such disability must be furnished to the insurer at such intervals as the insurer may reasonably require, and that in the case of claim for any other loss, written proof of such loss must be furnished to the insurer within ninety days after the date of such loss. Failure to furnish such proof within such time shall not invalidate nor reduce any claim if it was not reasonably possible to furnish such 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 of the claimant, later than one year from the time proof is otherwise required.

11. A provision that all benefits payable under the policy other than benefits for loss of time will be payable not more than sixty days after receipt of proof, and that, subject to due proof of loss, all accrued benefits payable under the policy for loss of time will be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of such period will be paid as soon as possible after receipt of such proof.

12. A provision that benefits for loss of life of the person insured shall be payable to the beneficiary designated by the person insured. However, if the policy contains conditions pertaining to family status, the beneficiary may be the family member specified by the policy terms. In either case, payment of these benefits is subject to the provisions of the policy in the event no such designated or specified beneficiary is living at the death of the person insured. All other benefits of the policy shall be payable to the person insured. The policy may

also provide that if any benefit is payable to the estate of a person, or to a person who is a minor or otherwise not competent to give a valid release, the insurer may pay such benefit, up to an amount not exceeding five thousand dollars, to any relative by blood or connection by marriage of such person who is deemed by the insurer to be equitably entitled thereto.

13. A provision that the insurer shall have the right and opportunity to examine the person of the individual for whom claim is made when and so often as it may reasonably require during the pendency of claim under the policy and also the right and opportunity to make an autopsy in case of death where it is not prohibited by law.

14. A provision that no action at law or in equity shall be brought to recover on the policy prior to the expiration of sixty days after proof of loss has been filed in accordance with the requirements of the policy and that no such action shall be brought at all unless brought within three years from the expiration of the time which proof of loss is required by the policy.

SECTION 4. **Dependent group health insurance.** A group health insurance policy may be extended to insure the employees or members with respect to their family members or dependents, or any class or classes thereof, subject to the following:

1. The premium for the insurance shall be paid either from funds contributed by the employer, union, association, or other person to whom the policy has been issued, or from funds contributed by the covered persons, or from both. A policy on which no part of the premium for the family members or dependents coverage is to be derived from funds contributed by the covered persons must insure all eligible employees or members with respect to their family members or dependents, or any class or classes thereof.

2. An insurer may exclude or limit the coverage on any family member or dependent as to whom evidence of individual insurability is not satisfactory to the insurer.

3. A policy which provides coverage for a dependent child of an employee or other member of the covered group, must provide such coverage up to a limiting age of nineteen years of age, if the dependent child physically resides with the employee or other member and is chiefly dependent upon the employee or member for support and maintenance.

4. A policy, which provides that coverage for a dependent child of an employee or other member of the covered group shall terminate upon attainment of the limiting age for dependent children specified in the policy, shall not operate to terminate the coverage of a dependent child:

(a) while the child is a full-time student and has not attained the age of twenty-three years of age; (b) while the child is and continues to be both incapable of self-sustaining employment by reason of mental retardation or physical handicap and chiefly dependent upon the employee or member for support and maintenance, provided proof of such incapacity and dependency is furnished to the insurer by the employee or member within thirty-one days of the child's attainment of limiting age and subsequently as may be required by the insurer but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

SECTION 5. Continuation of group hospital, surgical and major medical coverage after termination of employment or membership. A group policy delivered or issued for delivery in this state issued by any insurance company, nonprofit medical service corporation, nonprofit hospital service corporation, health maintenance organization or issued by any other insurer which provides hospital, surgical or major medical expense insurance or any accommodation of these coverages on an expense incurred basis, but not a policy which provides benefits for specific diseases or for accidental injuries only, shall provide that employees or members whose insurance under the group policy would otherwise terminate because of termination of employment or membership shall be entitled to continue their hospital, surgical and major medical insurance under that group policy, for themselves and their eligible dependents, subject to all of the group policy's terms and conditions applicable to those forms of insurance and to the following conditions:

1. Continuation shall only be available to an employee or member who has been continuously insured under the group policy (and for similar benefits under any group policy which it replaced) during the entire three months' period ending with such termination.

2. Continuation shall not be available for any person who is covered by medicare. Neither shall continuation be available for any person who is covered by any other insured or uninsured arrangement which provides hospital, surgical or medical coverages for individuals in a group and under which the person was not covered immediately prior to such termination.

3. Continuation need not include dental, vision care or prescription drug benefits or any other benefits provided under the group policy in addition to its hospital, surgical or major medical benefits.

4. An employee or member who wishes continuation of coverage must request such continuation in writing within the ten-day period following the later of the date of such termination, or the day the employee is given notice of the right of continuation by either his employer or the

group policyholder. In no event, however, may the employee or member elect continuation more than thirty-one days after the date of such termination.

5. An employee or member electing continuation must pay to the group policyholder or his employer, on a monthly basis in advance, the amount of contribution required by the policyholder or employer, but not more than the group rate for the insurance being continued under the group policy on the due date of each payment. The employee's or member's written election of continuation, together with the first contribution required to establish contributions on a monthly basis in advance, must be given to the policyholder or employer within thirty-one days of the date the employee's or member's insurance would otherwise terminate.

6. Continuation of insurance under the group policy for any person shall terminate when he fails to satisfy subsection 2 above or, if earlier, at the first to occur of the following:

   a. The date thirty-nine weeks after the date the employee's or member's insurance under the policy would otherwise have terminated because of termination of employment or membership.

   b. If the employee or member fails to make timely payment of a required contribution, the end of the period for which contributions were made.

   c. The date on which the group policy is terminated or, in the case of an employee, the date his employer terminates participation under the group policy. However, if this sudivision applies and the coverage ceasing by reason of such termination is replaced by similar coverage under another group policy, the following shall apply:

      (1) The employee or member shall have the right to become covered under that other group policy for the balance of the period that he would have remained covered under the prior group policy in accordance with subsection 6 had a termination described in this subdivision not occurred.

      (2) The minimum level of benefits to be provided by the other group policy shall be the applicable level of benefits of the prior group policy reduced by any benefits payable under that prior group policy.

      (3) The prior group policy shall continue to provide benefits to the extent of its accrued liabilities

and extensions of benefits as if the replacement had not occurred.

7. A notification of the continuation privilege shall be included in each certificate of coverage.

8. Upon termination of the continuation period, the member, surviving spouse, or dependent shall be entitled to exercise any option which is provided in the group plan to elect a conversion policy. The member electing a conversion policy shall notify the carrier of such election and pay the required premium within thirty-one days of the termination of the continued coverage under the group contract.

Approved April 13, 1983

CHAPTER 324

HOUSE BILL NO. 1232
(Committee on Industry, Business, and Labor)
(At the request of the Commissioner of Insurance)

SURPLUS LINES INSURANCE

AN ACT to amend and reenact sections 26-09.2-04, 26-09.2-05, and 26-09.2-11 of the North Dakota Century Code, relating to requirements for the utilization of surplus lines insurance.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26-09.2-04 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-09.2-04. Affidavit as prerequisite of insurance - Contents. ~~Before the person named in such license shall procure, effect or issue any such insurance policy or indemnity contract or surety bond, he shall in every case execute and file with the commissioner his affidavit in acceptable form that the insured is unable, after diligent search, to procure the insurance, indemnity contract, or surety bond desired from a company authorized to do business in this state.~~ The person named in the license shall in every case execute and file with the commission within fifteen days of the effective date of any such insurance policy or indemnity contract or surety bond an affidavit in acceptable form that after a diligent search, an inability exists to procure the insurance, indemnity contract, or surety bond desired from a company authorized to do business in this state. There is a presumption that such inability exists and that a diligent search has been made if the insurance, indemnity contract, or surety bond provides coverage listed by the commissioner as an approved surplus lines coverage. If the commissioner concurs in the allegation set forth in the affidavit the commissioner may authorize the procuring of the insurance, indemnity contract or bond from a company not authorized to do business in this state.

SECTION 2. AMENDMENT. Section 26-09.2-05 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-09.2-05. Endorsement of policy. Every policy issued under this section shall be endorsed "~~Issued in an unauthorized company, under~~

~~agent's license No. ------", which endorsement shall be properly filled in and signed by the agent.~~ "THIS POLICY IS ISSUED PURSUANT TO THE NORTH DAKOTA SURPLUS LINES INSURANCE STATUTE UNDER SURPLUS LINES BROKER'S LICENSE NO. -------. THE INSURER IS A QUALIFIED SURPLUS LINES INSURER, BUT IS NOT OTHERWISE LICENSED BY THE STATE OF NORTH DAKOTA AND DOES NOT PARTICIPATE IN THE NORTH DAKOTA INSURANCE GUARANTY ASSOCIATION."

The endorsement shall be properly completed and signed by the surplus lines broker.

SECTION 3. AMENDMENT. Section 26-09.2-11 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-09.2-11. Surplus lines in solvent insurers. A surplus lines insurance broker shall not knowingly place "surplus line" insurance with insurers unsound financially. The surplus lines insurance broker shall ascertain the financial condition of the unauthorized insurer before placing insurance therewith. The surplus lines insurance broker shall not so insure with ~~any stock insurer having capital and surplus amounting to less than two hundred fifty thousand dollars, or with any other type of insurer having assets of less than two hundred thousand dollars, of which not less than one hundred thousand dollars is surplus:~~

1. Any insurer organized under the laws of any state having less than five hundred thousand dollars of capital and five hundred thousand dollars in surplus, if a stock company, and five hundred thousand dollars in surplus, if a mutual company.

2. Any alien insurer which has not established an effective trust fund of at least one million dollars within the United States administered by a recognized financial institution and held for the benefit of all its policyholders in the United States or policyholders and creditors in the United States.

Approved March 8, 1983

CHAPTER 325

SENATE BILL NO. 2253
(Committee on Industry, Business, and Labor)
(At the request of the Insurance Department)

LIFE INSURANCE VALUATION

AN ACT to create and enact sections 26-10.1-03.1 and 26-10.1-09 of the North Dakota Century Code; and to amend and reenact sections 26-10.1-02, 26-10.1-03, 26-10.1-04, 26-10.1-05, 26-10.1-06, 26-10.1-07, 26-10.1-08, and 26-10.1-10 of the North Dakota Century Code, relating to the standard valuation law for life insurance.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26-10.1-02 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-10.1-02. Minimum standards of valuation for life insurance. The minimum standards for the valuation of all life or accident insurance policies issued prior to July 1, 1977, shall be those provided by sections 26-03-33, 26-03-34, and 26-10-01.* Except as otherwise provided in ~~section~~ sections 26-10.1-03 and 26-10.1-03.1, the minimum standard for the valuation of all such policies and contracts issued on and after July 1, 1977, shall be the commissioners' reserve valuation methods defined in sections 26-10.1-04, 26-10.1-05, and 26-10.1-08; five and one-half percent interest for single premium life insurance policies and four and one-half percent interest for all other such policies and contracts, other than annuity and pure endowment contracts, and the following tables:

1. For all policies of ordinary life insurance issued on the standard basis, excluding any disability and accidental death benefits in such policies, the commissioners' 1958 standard ordinary mortality table for such policies issued on or after the operative date of section 26-03.2-05 of the standard nonforfeiture law for life insurance and prior to the earlier of a specified date filed by a company with the commissioner in a written notice of the companies election to comply with this chapter or January 1, 1989, provided that for any category of such policies

issued on female risks, all modified net premiums and present values referred to in this chapter may be calculated according to an age not more than six years younger than the actual age of the insured; and for such policies issued on or after the earlier of a specified date filed by a company with the commissioner in a written notice of the companies election to comply with this chapter or January 1, 1989:

a. The commissioners 1980 standard ordinary mortality table;

b. At the election of the company for any one or more specified plans of life insurance, the commissioners 1980 standard ordinary mortality table with ten-year select mortality factors; or

c. Any ordinary mortality table, adopted after 1980 by the national association of insurance commissioners, that is approved by rule adopted by the commissioner for use in determining the minimum standard of valuation for such policies.

2. For all policies of industrial life insurance issued on the standard basis, excluding any disability and accidental death benefits in such policies, the commissioners' 1961 standard industrial mortality table or any industrial mortality table, adopted after 1980 by the national association of insurance commissioners, that is approved by rule adopted by the commissioner for use in determining the minimum standard of valuation for such policies.

3. For total and permanent disability benefits in or supplementary to policies or contracts, the tables of period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 disability study of the society of actuaries, with due regard to the type of benefit or any tables of disablement rates and termination rates, adopted after 1980 by the national association of insurance commissioners, that are approved by rule adopted by the commissioner for use in determining the minimum standard of valuation for such policies. Any such table shall, for active lives, be combined with a mortality table permitted for calculating the reserves for life insurance policies.

4. For accidental death benefits in or supplementary to policies or contracts, the 1959 accidental death benefits table or any accidental death benefits table, adopted after 1980 by the national association of insurance commissioners, that is approved by rule adopted by the commissioner for use in determining the minimum standard of valuation for such policies. Such table shall be

combined with a mortality table permitted for calculating the reserves for life insurance policies.

5. For group life insurance, life insurance issued on the substandard basis and other special benefits, such tables as may be approved by the commissioner.

SECTION 2. AMENDMENT. Section 26-10.1-03 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-10.1-03. Minimum standards of valuation for annuities. ~~The~~ Except as provided in section 26-10.1-03.1, the minimum standards for the valuation of all individual annuity and pure endowment contracts, and for all annuities and pure endowments purchased under group annuity and pure endowment contracts, shall be the commissioners' reserve valuation methods defined in sections 26-10.1-04 and 26-10.1-05 and the following tables and interest rates:

1. For individual single premium immediate annuity contracts, excluding any disability and accidental death benefits in such contracts, the 1971 individual annuity mortality table or any individual annuity mortality table, adopted after 1980 by the national association of insurance commissioners, that is approved by rule adopted by the commissioner for use in determining the minimum standard of valuation for such contracts, or any modification of ~~this table~~ these tables approved by the commissioner, and seven and one-half percent interest.

2. For individual annuity and pure endowment contracts, other than single premium immediate annuity contracts, excluding any disability and accidental death benefits in such contracts, the 1971 individual annuity mortality table or any individual annuity mortality table, adopted after 1980 by the national association of insurance commissioners, that is approved by rule adopted by the commissioner for use in determining the minimum standard of valuation for such contracts, or any modification of ~~this table~~ these tables approved by the commissioner, and five and one-half percent interest for single premium deferred annuity and pure endowment contracts and four and one-half percent interest for all other such individual annuity and pure endowment contracts.

3. For all annuities and pure endowments purchased under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under such contracts, the 1971 group annuity mortality table or any group annuity mortality table, adopted after 1980 by the national association of insurance commissioners, that is approved by rule adopted by the commissioner for use in determining the minimum standard of valuation for such annuities and pure endowments, or any modification of ~~this~~

~~table~~ these tables approved by the commissioner, and seven and one-half percent interest.

SECTION 3. Section 26-10.1-03.1 to the North Dakota Century Code is hereby created and enacted to read as follows:

26-10.1-03.1 - Determination of standard for valuation - Interest rates. The calendar year statutory valuation interest rates as defined in this section are:

1. The interest rates used in determining the minimum standard for the valuation of:

   a. All life insurance policies issued in a particular calendar year, on or after the earlier of a specified date filed by a company with the commissioner in a written notice of the companies election to comply with this chapter or January 1, 1989.

   b. All individual annuity and pure endowment contracts issued in a particular calendar year on or after January 1, 1984.

   c. All annuities and pure endowments purchased in a particular calendar year on or after January 1, 1984 under group annuity and pure endowment contracts.

   d. The net increase, if any, in a particular calendar year after January 1, 1984, in amounts held under guaranteed interest contracts.

2. The calendar year statutory valuation interest rates, I, shall be determined as follows and the results rounded to the nearer one-quarter of one percent:

   a. For life insurance:

$$I = .03 + W (R_1 - .03) + \frac{W}{2} (R_2 - .09)$$

   b. For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and from guaranteed interest contracts with cash settlement options:

$I = .03 + W (R - .03)$

where R_1 is the lesser of R and .09, R_2 is the greater of R and .09, R is the reference interest rate defined in this section, and W is the weighting factor defined in this section.

c. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on an issue year basis, except as stated in subdivision b, the formula for life insurance stated in subdivision a applies to annuities and guaranteed interest contracts with guarantee durations in excess of ten years and the formula for single premium immediate annuities stated in subdivision b applies to annuities and guaranteed interest contracts with guarantee duration of ten years or less.

d. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the formula for single premium immediate annuities stated in subdivision b applies.

e. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, the formula for single premium immediate annuities stated in subdivision b applies.

However, if the calendar year statutory valuation interest rate for any life insurance policies issued in any calendar year determined without reference to this sentence differs from the corresponding actual rate for similar policies issued in the immediately preceding calendar year by less than one-half of one percent, the calendar year statutory valuation interest rate for such life insurance policies shall be equal to the corresponding actual rate for the immediately preceding calendar year. For purposes of applying the immediately preceding sentence, the calendar year statutory valuation interest rate for life insurance policies issued in a calendar year shall be determined for 1980 (using the reference interest rate defined for 1979) and shall be determined for each subsequent calendar year regardless of when section 26-03.2-07 of the standard nonforfeiture law for life insurance becomes operative.

3. The weighting factors referred to in the formulas in subsection 2 are given in the following tables:

a. The weighting factors for life insurance are:

Guarantee Duration	Weighting

(Years)	Factors
10 or less	.50
More than 10, but not more than 20	.45
More than 20	.35

For life insurance, the guarantee duration is the maximum number of years the life insurance can remain in force on a basis guaranteed in the policy or under options to convert to plans of life insurance with premium rates or nonforfeiture values or both which are guaranteed in the original policy.

b. The weighting factor for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options is: .80

c. The weighting factors for other annuities and for guaranteed interest contracts, except as stated in subdivision b, are as specified in paragraphs 1, 2, and 3, according to the rules and definitions in paragraphs 4, 5, and 6:

(1) For annuities and guaranteed interest contracts valued on an issue year basis:

Guarantee Duration (Years)	Weighting Factor for Plan Type A	B	C
5 or less	.80	.60	.50
More than 5, but not more than 10	.75	.60	.50
More than 10, but not more than 20	.65	.50	.45
More than 20	.45	.35	.35

(2) For annuities and guaranteed interest contracts valued on a change in fund basis, the factors shown in (1) above increased by .15 .25 .05

(3) For annuities and guaranteed interest contracts valued on an issue year basis (other than those with no cash settlement options) which do not guarantee interest on considerations received

more than one year after issue or purchase and for annuities and guaranteed interest contracts valued on a change in fund basis which do not guarantee interest rates on considerations received more than twelve months beyond the valuation date, the factors shown in paragraph (1) or derived in paragraph (2) increased by .05 .05 .05

(4) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the guarantee duration is the number of years for which the contract guarantees interest rates in excess of the calendar year statutory valuation interest rate for life insurance policies with guarantee duration in excess of twenty years. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the guarantee duration is the number of years from the date of issue or date of purchase to the date annuity benefits are scheduled to commence.

(5) The plan type as used in the tables in this subsection is defined as follows:

(a) Plan Type A: At any time the policyholder may withdraw funds only (1) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company, (2) without such adjustment but in installments over five years or more, (3) as an immediate life annuity, or (4) no withdrawal permitted.

(b) Plan Type B: Before expiration of the interest rate guarantee, the policyholder may withdraw funds only (1) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company, (2) without such adjustment but in installments over five years or more, or (3) no withdrawal permitted. At the end of interest rate guarantee, funds may be withdrawn without

such adjustment in a single sum or installments over less than five years.

(c) Plan Type C: The policyholder may withdraw funds before expiration of interest rate guarantee in a single sum or installments over less than five years either (1) without adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company, or (2) subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund.

(6) A company may elect to value guaranteed interest contracts with cash settlement options and annuities with cash settlement options on either an issue year basis or on a change in fund basis. Guaranteed interest contracts with no cash settlement options and other annuities with no cash settlement options must be valued on an issue year basis. As used in this section, an issue year basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard for the entire duration of the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of issue or year of purchase of the annuity or guaranteed interest contract, and the change in fund basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard applicable to each change in the fund held under the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of the change in the fund.

4. The reference interest rate referred to in subsection 2 is defined as follows:

a. For all life insurance, the lesser of the average over a period of thirty-six months and the average over a period of twelve months, ending on June thirtieth of the calendar year next preceding the year of issue, of Moody's corporate bond yield average - monthly average corporates, as published by Moody's investors service, incorporated.

b. For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the average over a period of twelve months,

ending on June thirtieth of the calendar year of issue or year of purchase, of Moody's corporate bond yield average - monthly average corporates, as published by Moody's investors service, incorporated.

c. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in subdivision b with guarantee duration in excess of ten years, the lesser of the average over a period of thirty-six months and the average over a period of twelve months, ending on June thirtieth of the calendar year of issue or purchase, of Moody's corporate bond yield average - monthly average corporates, as published by Moody's investors service, incorporated.

d. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in subdivision b with guaranteed duration of ten years or less, the average over a period of twelve months, ending on June thirtieth of the calendar year of issue or purchase, of Moody's corporate bond yield average - monthly average corporates, as published by Moody's investors service, incorporated.

e. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the average over a period of twelve months, ending on June thirtieth of the calendar year of issue or purchase, of Moody's corporate bond yield average - monthly average corporates, as published by Moody's investors service, incorporated.

f. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, except as stated in subdivision b the average over a period of twelve months, ending on June thirtieth of the calendar year of the change in the fund, of Moody's corporate bond yield average - monthly average corporates, as published by Moody's investors service, incorporated.

5. If Moody's corporate bond yield average - monthly average corporates is no longer published by Moody's investors service, incorporated, or if the national association of insurance commissioners determines that Moody's corporate bond yield average - monthly average corporates as published by Moody's investors service, incorporated is no longer appropriate for the determination of the reference interest rate, then an alternative method for

determination of the reference interest rate, which is adopted by the national association of insurance commissioners and approved by rule adopted by the commissioner, may be substituted.

SECTION 4. AMENDMENT. Section 26-10.1-04 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-10.1-04. Reserves by commissioners' reserve valuation method. Except as otherwise provided in sections 26-10.1-05 and 26-10.1-08, reserves according to the commissioners' reserve valuation method, for the life insurance and endowment benefits of policies providing for a uniform amount of insurance and requiring the payment of uniform premiums, shall be the excess, if any, of the present value, at the date of valuation, of such future guaranteed benefits provided by such policies, over the then present value of any future modified net premiums therefor. The modified net premiums for any such policy shall be such uniform percentage of the respective contract premiums for such benefits that the present value, at the date of issue of the policy, of all such modified net premiums shall be equal to the sum of the then present value of such benefits provided by the policy and the excess of 1 over 2 as follows:

1. A net level annual premium equal to the present value, at the date of issue, of such benefits provided after the first policy year, divided by the present value, at the date of issue, of an annuity of one per year payable on the first and each subsequent anniversary of such policy on which a premium falls due; provided, however, that such net level annual premium shall not exceed the net level annual premium on the nineteen-year premium whole life plan for insurance of the same amount at an age one year higher than the age at issue of such policy.

2. A net one-year term premium for such benefits provided in the first policy year.

However, for any life insurance policy issued on or after January 1, 1987, for which the contract premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess and which provides an endowment benefit or a cash surrender value or a combination thereof in an amount greater than such excess premium, the reserve according to the commissioners reserve valuation method as of any policy anniversary occurring on or before the assumed ending date defined herein as the first policy anniversary on which the sum of any endowment benefit and any cash surrender value then available is greater than such excess premium shall, except as otherwise provided in section 26-10.1-08, be the greater of the reserve as of such policy anniversary calculated as described in this section and the reserve as of such policy anniversary calculated as described in this section, but with (a) the value defined in subsection 1 being reduced by fifteen percent of the

amount of such excess first year premium; (b) all present values of benefits and premiums being determined without reference to premiums or benefits provided for by the policy after the assumed ending date; (c) the policy being assumed to mature on such date as an endowment; and (d) the cash surrender value provided on such date being considered as an endowment benefit. In making the above comparison the mortality and interest bases stated in sections 26-10.1-02 and 26-10.1-03.1 shall be used.

Reserves according to the commissioners' reserve valuation method for: (a) life insurance policies providing a varying amount of insurance or requiring the payment of varying premiums; (b) group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under section 408 of the Internal Revenue Code, as now or hereafter amended; (c) disability and accidental death benefits in all policies and contracts; and (d) all other benefits, except life insurance and endowment benefits in life insurance policies and benefits provided by all other annuity and pure endowment contracts, shall be calculated by a method consistent with the principles of the preceding ~~paragraph~~ paragraphs of this section.

SECTION 5. AMENDMENT. Section 26-10.1-05 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-10.1-05. Reserves by commissioners' annuity reserve method. This section shall apply to all annuity and pure endowment contracts ~~except~~ other than group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under section 408 of the Internal Revenue Code of 1954, as now or hereafter amended.

Reserves according to the commissioners' annuity reserve method for benefits under annuity or pure endowment contracts, excluding any disability and accidental death benefits in such contracts, shall be the greatest of the respective excesses of the present values, at the date of valuation, of the future guaranteed benefits, including guaranteed nonforfeiture benefits, provided for by such contracts at the end of each respective contract year, over the present value, at the date of valuation, of any future valuation considerations derived from future gross considerations, required by the terms of such contract, that become payable prior to the end of such respective contract year. The future guaranteed benefits shall be determined by using the mortality tables, if any, and the interest rate, or rates, specified in such contracts for determining guaranteed benefits. The valuation considerations are the portions

of the respective gross considerations applied under the terms of such contracts to determine nonforfeiture values.

SECTION 6. AMENDMENT. Section 26-10.1-06 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-10.1-06. Minimum aggregate reserves. In no event shall a company's aggregate reserves for all life insurance policies, excluding disability and accidental death benefits, issued on ~~and~~ or after July 1, 1977, be less than the aggregate reserves calculated in accordance with the methods set forth in sections 26-10.1-04, 26-10.1-05, and 26-10.1-08 and the mortality table or tables and rate or rates of interest used in calculating nonforfeiture benefits for such policies.

SECTION 7. AMENDMENT. Section 26-10.1-07 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-10.1-07. Minimum aggregate reserves. Reserves for all policies and contracts issued prior to July 1, 1977, may be calculated, at the option of the company, according to any standards which produce greater aggregate reserves for all such policies and contracts than the minimum reserves required by the laws in effect immediately prior to such date.

Reserves for any category of policies, contracts, or benefits, as established by the commissioner, issued on or after July 1, 1977, may be calculated, at the option of the company, according to any standards which produce greater aggregate reserves for such category than those calculated according to the minimum ~~standards~~ standard herein provided, but the rate or rates of interest used for policies and contracts, other than annuity and pure endowment contracts, shall not be higher than the corresponding rate or rates of interest used in calculating any nonforfeiture benefits provided therein. Any such company which at any time shall have adopted any ~~standards~~ standard of valuation producing greater aggregate reserves than those calculated according to the minimum ~~standards~~ standard herein provided may, with the approval of the commissioner, adopt any lower ~~standards~~ standard of valuation, but not lower than the minimum herein provided.

SECTION 8. AMENDMENT. Section 26-10.1-08 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-10.1-08. Minimum reserve where net premium exceeds gross premium. If in any contract year the gross premium charged by any life insurance company on any policy or contract is less than the valuation net premium for the policy or contract calculated by the method used in calculating the reserve thereon but using the minimum valuation standards of mortality and rate of interest, the minimum reserve required for such policy or contract is the greater of

either the reserve calculated according to the mortality table, rate of interest, and method actually used for such policy or contract, or the reserve calculated by the method actually used for such policy or contract but using the minimum valuation standards of mortality and rate of interest and replacing the valuation net premium by the actual gross premium in each contract year for which the valuation net premium exceeds the actual gross premium. The minimum valuation standards of mortality and rate of interest referred to in this section are those standards stated in sections 26-10.1-02 and 26-10.1-03.1.

However, for any life insurance policy issued on or after January 1, 1987, for which the gross premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess and which provides an endowment benefit or a cash surrender value or a combination thereof in an amount greater than such excess premium, the foregoing provisions of this section shall be applied as if the method actually used in calculating the reserve for such policy were the method described in section 26-10.1-04, ignoring the second paragraph of section 26-10.1-04. The minimum reserve at each policy anniversary of such a policy shall be the greater of the minimum reserve calculated in accordance with section 26-10.1-04, including the second paragraph of that section, and the minimum reserve calculated in accordance with this section.

SECTION 9. Section 26-10.1-09 to the North Dakota Century Code is hereby created and enacted to read as follows:

26-10.1-09. Future premium determination. In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurance company based on then estimates of future experience, or in the case of any plan of life insurance or annuity which is of such a nature that the minimum reserves cannot be determined by the methods described in sections 26-10.1-04, 26-10.1-05, and 26-10.1-08, the reserves which are held under any such plan must be appropriate in relation to the benefits and the pattern of premiums for that plan, and must be computed by a method which is consistent with the principles of this standard valuation law, as determined by rules adopted by the commissioner.

Approved March 10, 1983

CHAPTER 326

HOUSE BILL NO. 1227
(Committee on Industry, Business, and Labor)
(At the request of the Commissioner of Insurance)

INSURANCE LICENSE REQUIREMENTS

AN ACT to create and enact section 26-17.1-13.1 of the North Dakota Century Code, relating to renewal of appointments and annual fees; and to amend and reenact sections 26-17.1-06, 26-17.1-07, 26-17.1-12, 26-17.1-13, 26-17.1-14, 26-17.1-15, 26-17.1-18, 26-17.1-20, 26-17.1-28, 26-17.1-31, 26-17.1-32, 26-17.1-33, 26-17.1-35, 26-17.1-41, and 26-17.1-42 of the North Dakota Century Code, relating to the qualifications and procedures for the licensing of insurance agents, insurance brokers, surplus lines insurance brokers, insurance consultants, and limited insurance representatives; and to provide a penalty.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26-17.1-06 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-17.1-06. Acting as insurance agent, insurance broker, surplus lines insurance broker, or limited insurance representative without license prohibited - Penalty. No person, partnership, association, or corporation shall act as or hold himself out to be an insurance agent, insurance broker, surplus lines insurance broker, limited insurance representative, or consultant unless duly licensed. No insurance agent, insurance broker, surplus lines insurance broker, or limited insurance representative shall make application for, procure, negotiate for, or place for others, any policy for any lines of insurance as to which he is not then qualified and duly licensed. No insurance agent or limited insurance representative shall place a policy of insurance with any insurer as to which he does not then hold a license as an insurance agent or limited insurance representative under this chapter. Any person violating this section is guilty of a class B misdemeanor.

SECTION 2. AMENDMENT. Section 26-17.1-07 of the 1981 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-17.1-07. Qualification for license - Lines of insurance. An insurance agent, insurance broker, or surplus lines insurance broker may receive qualification for a license in one or more of the following lines:

1. Life insurance and annuity contracts.
2. Sickness, accident, and health.
3. Credit life insurance and credit accident and health.
4. Fire and allied lines.
5. Vehicle liability and vehicle physical damage insurance.
6. Comprehensive personal and general liability coverage.
7. Marine and transportation.
8. Credit and mortgage guarantee insurance.
9. Burglary and theft insurance.
10. Crop insurance.
11. Bail bonds.
12. Fidelity and surety insurance.
13. Homeowners' and farmowners' multiple peril insurance.
14. Commercial multiple peril insurance.
15. Property and casualty insurance sold in connection with a credit transaction.
16. Industrial fire.
17. Legal expense insurance.
18. Variable annuities and variable life insurance.
19. Title insurance.

SECTION 3. AMENDMENT. Section 26-17.1-12 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-17.1-12. Contents of license --~~License to specify appointing insurer~~. The license shall state the name, resident address, social security or IRS identification number of the licensee, date of issue, ~~renewal or expiration date,~~ and the line or lines of insurance covered by the license, and provide such other information as the commissioner deems proper for inclusion in the license. ~~The~~

~~license of an insurance agent or limited insurance representative shall specify the name of the particular insurer by which the licensee is appointed.~~ An insurance agent or limited insurance representative may represent as many insurers as may appoint him in accordance with this chapter.

* SECTION 4. AMENDMENT. Section 26-17.1-13 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-17.1-13. Term of license. ~~All licenses issued pursuant to this chapter shall continue in force not longer than twelve months, but shall expire as of 12:01 a.m. on the first day of May next following date of issuance unless the licensee prior thereto has filed with the commissioner, on forms prescribed and furnished by him, a request for renewal of such license for an ensuing twelve-month period. Such request must be accompanied by payment of the renewal fee as provided in section 26-01-04.~~ Licenses issued pursuant to this chapter shall continue in force in perpetuity unless:

1. The license is revoked, suspended, or terminated by the commissioner of insurance;

2. The licensee voluntarily consents to the revocation, suspension, or termination of his license;

3. The licensee is deceased or in the case of a corporation or partnership, the licensee is dissolved, consolidated, merged, or otherwise has ceased to exist;

4. The licensee no longer meets the residence requirements of section 26-17.1-20;

5. The agent or limited insurance representative is terminated or nonrenewed by all appointing insurers;

6. The broker or surplus lines broker has failed to maintain a bond as required by section 26-17.1-17, has failed to maintain a resident or nonresident insurance agents license as required by section 26-17.1-18, or has failed to pay the annual renewal fee to the commissioner; or

7. The consultant has failed to pay the annual renewal fee to the commissioner.

SECTION 5. Section 26-17.1-13.1 of the North Dakota Century Code is hereby created and enacted to read as follows:

26-17.1-13.1. Renewal of appointments and licenses - Annual fee. An appointment of an agent or limited insurance representative and the license of a broker, surplus lines broker or consultant terminates upon failure to pay before May first the prescribed

* NOTE: Section 26-17.1-13 was also amended by section 19 of House Bill No. 1055, chapter 319.

annual renewal fee. This section also applies to all licenses issued pursuant to section 26-17.1-09.

SECTION 6. AMENDMENT. Section 26-17.1-14 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-17.1-14. Exceptions to licensing requirements. No license as an insurance agent, insurance broker, surplus lines insurance broker, or limited insurance representative shall be required of the following:

1. Any regular salaried officer or employee of an insurance company, licensed insurance agent, insurance broker, surplus lines insurance broker, or limited insurance representative if such officer's or employee's duties and responsibilities do not include the negotiation or solicitation of insurance.

2. Persons who secure and furnish information for the purpose of group or wholesale life insurance, annuities, or group, blanket, or franchise health insurance, or for enrolling individuals under such plans or issuing certificates thereunder or otherwise assisting in administering such plans, where no commission is paid for such service.

3. Employers or their officers or employees or the trustees of any employee trust plan, to the extent that such employers, officers, employees, or trustees are engaged in the administration or operation of any program of employee benefits for their own employees or the employees of their subsidiaries or affiliates involving the use of insurance issued by a licensed insurance company, provided, that such employers, officers, employees, or trustees are not in any manner compensated, directly or indirectly, by the insurance company issuing such insurance.

4. Employees of a creditor who enrolls debtors under a group policy; provided, that such employees receive no commission or other compensation directly related to such enrollment.

SECTION 7. AMENDMENT. Section 26-17.1-15 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-17.1-15. License requirements - Application - Appointment by company - Age. Application shall be made to the commissioner by the applicant on a form prescribed by the commissioner.

The application for an insurance agent or limited insurance representative license shall be accompanied by a written appointment. Such appointment shall be made by an officer of the insurer designating the applicant as an insurance agent or limited

insurance representative for such lines of insurance as the applicant will be authorized to write for said insurer. All appointments for any licensee shall be submitted on behalf of the appointing insurer, on a form prescribed by the commissioner, and shall remain in force until 12:01 a.m. on the annual renewal date ~~which shall be May 1~~.

Every applicant for an insurance agent or limited insurance representative license under this chapter, except a partnership or corporation, must be eighteen years or more of age.

SECTION 8. AMENDMENT. Section 26-17.1-18 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-17.1-18. License requirement - Insurance brokers - Experience. Each applicant for an insurance broker's license must have had not less than two years' experience as an insurance agent or in comparable employment for an insurance company, agency, or brokerage firm during the three years immediately next preceding the date of application and must hold and maintain a resident or nonresident insurance agent's license in this state. The application for an insurance broker's license must be accompanied by an affidavit from the employer or insurer to the effect that the applicant was so engaged in such required responsible insurance duties.

SECTION 9. AMENDMENT. Section 26-17.1-20 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-17.1-20. License requirement - Residency - Election of residency - When void --~~When resident licensee allowed to hold resident license from another state~~. An applicant may qualify as a resident if he resides in this state or maintains his principal place of business in this state. Any license issued pursuant to any such application claiming residency for licensing purposes, as defined herein, in this state shall constitute an election of residency in this state and shall be void if the licensee, while holding a resident license in this state, also holds or makes application for a license in, or thereafter claims to be a resident of, any other state or other jurisdiction or ceased to be a resident of this state~~, provided, however, if the applicant is a resident of a community or trade area, the border of which is contiguous with the state line of this state, the applicant may qualify as a resident in such states and hold a license from each state~~.

SECTION 10. AMENDMENT. Section 26-17.1-28 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-17.1-28. Examination - Individuals. ~~After completion and filing of the application with the commissioner, except~~ Except as provided in section 26-17.1-35, the commissioner shall subject each applicant for license as an insurance agent, insurance broker, surplus lines

insurance broker, consultant, or limited insurance representative to a written examination as to his competence to act as such licensee which he must personally take and pass to the satisfaction of the commissioner.

SECTION 11. AMENDMENT. Section 26-17.1-31 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-17.1-31. Examination - Lines of insurance - Time and place - Duties of commissioner. ~~All the lines of insurance which the applicant proposes to transact under the license applied for shall have a separate examination.~~

Examination for licensing shall be at such reasonable times and places as are designated by the commissioner ~~and such times and places shall be made public sixty days after the effective date of this chapter~~.

The commissioner shall give, conduct, and grade all examinations in a fair and impartial manner and without discrimination as between individuals examined.

The applicant must pass the examination with a grade determined by the commissioner to indicate satisfactory knowledge and understanding of the ~~line or lines~~ area of insurance for which the applicant seeks qualification. Within ten days or as soon as is reasonable after the examination, the commissioner shall inform the applicant and the appointing insurer, where applicable, as to whether or not the applicant has passed. Formal evidence of said licensing shall be issued by the commissioner to the licensee within a reasonable time.

SECTION 12. AMENDMENT. Section 26-17.1-32 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-17.1-32. Examination - Failure to pass. An applicant who has failed to pass the first examination for the license applied for may ~~take a second~~ retake the examination ~~after a thirty-day waiting period~~. Examination fees for subsequent examinations shall not be waived.

~~An applicant who has failed to pass the first two examinations for the license applied for will not be permitted to take a subsequent examination until the expiration of six months after the last previous examination.~~

SECTION 13. AMENDMENT Section 26-17.1-33 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-17.1-33. Denial of license - Notification of applicant - No refund of appointment fee. If the commissioner finds that the applicant has not

fully met the requirements for licensing, he shall refuse to issue the license and promptly notify the applicant and the appointing insurer, in writing, of such denial, stating the grounds therefor.

~~If a license is refused, the commissioner shall promptly refund the appointment fee tendered with the license application.~~ All ~~other~~ fees accompanying the application for license as insurance agent, insurance broker, surplus lines insurance broker, consultant, and limited insurance representative shall be deemed earned and shall not be refundable.

SECTION 14. AMENDMENT. Section 26-17.1-35 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-17.1-35. Exemption from examination. The following shall be exempt from the requirement for a written examination:

1. Any applicant for a license covering the same line or lines of insurance for which the applicant was licensed under a like resident license in this state, other than a temporary license, within the twelve months next preceding the date of application, unless such previous license was revoked or suspended or continuation thereof was refused by the commissioner.

2. An applicant who has been licensed under a like license in another state within twelve months prior to his application for a license in this state, and who files with the commissioner the certificate of the public official having supervision of insurance in such other state as to the applicant's license and good standing in such state; provided, however, such applicant shall be required to take that portion of the examination pertaining to rules, regulations, and state laws. A facsimile signature and seal of the certifying public official will be deemed sufficient.

3. An applicant who has attained the designation of chartered life underwriter shall only be required to take that portion of the examination for ~~line~~ lines 1 and 18 pertaining to rules, regulations, and state laws.

4. An applicant who has attained the designation of chartered property and casualty underwriter shall only be required to take that portion of the examination for lines 2 through ~~16~~ 17 pertaining to rules, regulations, and state laws.

SECTION 15. AMENDMENT. Section 26-17.1-41 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-17.1-41. Insurance consultant - Term of license - Denial, revocation, or suspension of license - Duties of consultant. Such license shall be valid ~~for not longer than twelve months and may be renewed annually and extended in the same manner as an insurance agent's license~~ in perpetuity by remittance of an annual fee.

All requirements and standards relating to the denial, revocation, or suspension of an insurance agent's license, including penalties, shall apply to the denial, revocation, and suspension of an insurance consultant's license as nearly as practicable.

A consultant is obligated under his license to serve with objectivity and complete loyalty the interests of his client alone and to render his client such information, counsel, and service as within the knowledge, understanding, and opinion, in good faith of the licensee, best serves the client's insurance needs and interests.

SECTION 16. AMENDMENT. Section 26-17.1-42 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-17.1-42. License denial, nonrenewal, or termination - Grounds. The commissioner may suspend, revoke, or refuse to continue ~~or renew~~ or refuse to issue any license issued under this chapter if, after notice to the licensee ~~and the insurer represented~~ and hearing, he finds as to the licensee any one or more of the following conditions:

1. Any materially untrue statement in the license application.

2. Any cause for which issuance of the license could have been refused had it then existed and been known to the commissioner at the time of issuance.

3. Violation of, or noncompliance with, any insurance laws, or for violation of any lawful rules, regulation, or order of the commissioner or of a commissioner of another state.

4. Obtaining or attempting to obtain any such license through misrepresentation or fraud.

5. Improperly withholding, misappropriating, or converting to his own use any moneys belonging to policyholders, insurers, beneficiaries, or others received in the course of his insurance business.

6. Misrepresentation of the terms of any actual or proposed insurance contract.

7. Conviction of an offense determined by the commissioner to have a direct bearing upon a person's ability to serve the public as an insurance agent, broker, representative, or

consultant, or the commissioner finds, after conviction of an offense, that the person is not sufficiently rehabilitated under section 12.1-33-02.1.

8. The licensee has been found guilty of any unfair trade practice or fraud defined in this title.

9. In the conduct of his affairs under the license, the licensee has used fraudulent, coercive, or dishonest practices, or has shown himself to be incompetent, untrustworthy, or financially irresponsible.

10. His license has been suspended or revoked in any other state, province, district, or territory.

11. Such licensee has forged another's name to an application for insurance.

12. Such applicant has been found to have been cheating on an examination for an insurance license.

13. Such licensee has been found to have knowingly solicited, procured, or sold unnecessary, or excessive insurance coverage to any person.

Approved March 4, 1983

CHAPTER 327

HOUSE BILL NO. 1226
(Committee on Industry, Business, and Labor)
(At the request of the Commissioner of Insurance)

LIFE OR HEALTH INSURANCE ADMINISTRATORS

AN ACT to create and enact chapter 26-17.2 of the North Dakota Century Code, relating to administrators of life or health insurance coverage or annuities; and to provide a penalty.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. Chapter 26-17.2 of the North Dakota Century Code is hereby created and enacted as follows:

26-17.2-01. Administrator defined. Wherever the term "administrator" is used in this chapter, it shall be defined as any person who collects charges or premiums from, or who adjusts or settles claims on, residents of this state in connection with life or health insurance coverage or annuities other than:

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, health maintenance organization, nonprofit medical, hospital, dental or vision service corporation which is either licensed in this state or acting as an insurer with respect to a policy lawfully issued and delivered by it in and pursuant to the laws of a state in which the insurer was authorized to do an insurance business or prepaid medical, hospital, dental or vision care plan including their sales representatives licensed in this state when engaged in the performance of their duties as such;

4. A life or health agent or broker licensed in this state, whose activities are limited exclusively to the sale of insurance;

5. A creditor on behalf of its debtors with respect to insurance covering a debt between the creditor and its debtors;

6. A trust, its trustees, agents, and employees acting thereunder, established in conformity with 29 U.S.C. 186;

7. A trust exempt from taxation under Section 501 (a) of the United States Internal Revenue Code of 1954 as amended, its trustees, and employees acting thereunder, or a custodian, its agents and employees acting pursuant to a custodian account which meets the requirements of Section 401 (f) of the United States Internal Revenue Code of 1954 as amended;

8. A bank, credit union, or other financial institution which is subject to supervision or examination by federal or state banking authorities;

9. A credit card issuing company which advances for and collects premiums or charges from its credit cardholders who have authorized it to do so, provided such company does not adjust or settle claims; or

10. A person who adjusts or settles claims in the normal course of his practice or employment as an attorney at law, and who does not collect charges or premiums in connection with life or health insurance coverage or annuities.

26-17.2-01.1. Insurer defined. Wherever the term "insurer" is used in this chapter, it shall be defined as any corporation, association, benefit society, partnership or individual, including self-insurers, engaged as principals in the business of annuities or life or health insurance.

26-17.2-02. Written agreement necessary. No administrator shall act as such without a written agreement between the administrator and the insurer, and such written agreement shall be retained as part of the official records of both the insurer and the administrator for the duration of the agreement and five years thereafter. Such written agreement shall contain provisions which include the requirements of sections 26-17.2-04, 26-17.2-05, 26-17.2-06, 26-17.2-07, 26-17.2-08, and 26-17.2-09 except insofar as those requirements do not apply to the functions performed by the administrator.

Where a policy is issued to a trustee or trustees, a copy of the trust agreement and any amendments thereto shall be furnished to the insurer by the administrator and shall be retained as part of the official records of both the insurer and the administrator for the duration of the policy and five years thereafter.

26-17.2-03. Payment to administrator. Whenever an insurer utilizes the services of an administrator under the terms of a written contract as required in section 26-17.2-02, the payment to the administrator of any premiums or charges for insurance by or on behalf of the insured shall be deemed to have been received by the insurer, and the payment of return premiums or claims by the insurer to the administrator shall not be deemed payment to the insured or claimant until such payments are received by the insured or claimant. Nothing herein shall limit any right of the insurer against the administrator resulting from its failure to make payments to the insurer, insureds, or claimants.

26-17.2-04. Maintenance of information. Every administrator shall maintain at its principal administrative office for the duration of the written agreement referred to in section 26-17.2-02 and five years thereafter adequate books and records of all transactions between it, insurers and insured persons. Such books and records shall be maintained in accordance with prudent standards of insurance recordkeeping. The commissioner shall have access to such books and records for the purpose of examination, audit, and inspection. Any trade secrets contained therein, including but not limited to the identity and addresses of policyholders and certificateholders, shall be confidential, except the commissioner may use such information in any proceedings instituted against the administrator. The insurer shall retain the right to continuing access to such books and records of the administrator sufficient to permit the insurer to fulfill all of its contractual obligations to insured persons, subject to any restrictions in the written agreement between the insurer and administrator on the proprietary rights of the parties in such books and records.

26-17.2-05. Approval of advertising. An administrator may use only such advertising pertaining to the business underwritten by an insurer as has been approved by such insurer in advance of its use.

26-17.2-06. Underwriting provision. The agreement shall make provision with respect to the underwriting or other standards pertaining to the business underwritten by such insurer.

26-17.2-07. Premium collection. All insurance charges or premiums collected by an administrator on behalf of or for an insurer or insurers, and return premiums received from such insurer or insurers, shall be held by the administrator in a fiduciary capacity. Such funds shall be immediately remitted to the person or persons entitled thereto, or shall be deposited promptly in a fiduciary bank account established and maintained by the administrator. If charges or premiums so deposited have been collected on behalf of or for more than one insurer, the administrator shall cause the bank in which such fiduciary account is maintained to keep records clearly recording the deposits in and withdrawals from such account on behalf of or for each insurer. The administrator shall promptly obtain and keep copies of all such records and, upon request of an insurer, shall furnish such insurer with copies of such records pertaining to deposits and withdrawals

on behalf of or for such insurer. The administrator shall not pay any claim by withdrawals from such fiduciary account. Withdrawals from such account shall be made, as provided in the written agreement between the administrator and the insurer, for (1) remittance to an insurer entitled thereto; (2) deposit in an account maintained in the name of such insurer; (3) transfer to and deposit in a claims paying account, with claims to be paid as provided in section 26-17.2-08; (4) payment to a group policyholder for remittance to the insurer entitled thereto; (5) payment to the administrator of its commission, fees, or charges; or (6) remittance of return premiums to the person or persons entitled thereto.

26-17.2-08. Payment of claims. All claims paid by the administrator from funds collected on behalf of the insurer shall be paid only on drafts of and as authorized by such insurer.

26-17.2-09. Claim adjustment or settlement. With respect to any policies where an administrator adjusts or settles claims, the compensation to the administrator with regard to such policies shall in no way be contingent on claim experience. This section shall not prevent the compensation of an administrator from being based on premiums or charges collected or number of claims paid or processed.

26-17.2-10. Notification required. Where the services of an administrator are utilized, the administrator shall provide a written notice approved by the insurer, to insured individuals, advising them of the identity of and relationship among the administrator, the policyholder and the insurer. Where an administrator collects funds, it must identify and state separately in writing to the person paying to the administrator any charge or premium for insurance coverage the amount of any such charge or premium specified by the insurer for such insurance coverage.

26-17.2-11. Certificate of registration required.

1. No person may act as or hold himself out to be an administrator in this state, for the kinds of business for which the person is acting as an administrator, unless he shall hold a certificate of registration as an administrator issued by the commissioner of insurance. Any person violating the provisions of this subsection shall be guilty of a class B misdemeanor.

2. Such certificate shall be issued by the commissioner to an administrator unless the commissioner after due notice and hearing shall have determined that the administrator is not competent, trustworthy, financially responsible or of good personal and business reputation, or has had a previous application for an insurance license denied for cause within five years. All applications shall be accompanied by a filing fee of twenty-five dollars. The administrator shall pay an annual renewal fee of twenty-five dollars to maintain the certificate.

3. After notice and hearing, the commissioner may revoke such certificate or fine such administrator not more than ten thousand dollars, or both, or the commissioner may suspend such certificate, or fine such administrator not more than five thousand dollars, or both, upon finding that either the administrator violated any of the requirements of section 26-17.2-02 and sections 26-17.2-04, 26-17.2-05, 26-17.2-06, 26-17.2-07, 26-17.2-08, 26-17.2-09, and 26-17.2-10 thereof, or the administrator is not competent, trustworthy, financially responsible, or of good personal and business reputation.

26-17.2-12. Waiving of requirements. The commissioner may waive the requirements of section 26-17.2-11 for any person or class of persons. The factors taken into account in granting such waiver include, but not be limited to:

1. Whether the person acting as an administrator is primarily in a business other than that of administrator.

2. Whether the financial strength and history of the organization indicates stability in its continuity of doing business.

3. Whether the regular duties being performed as an administrator are such that the covered persons are not likely to be injured by a waiver of such requirements.

Approved March 8, 1983

CHAPTER 328

SENATE BILL NO. 2183
(Committee on Industry, Business, and Labor)
(At the request of the Commissioner of Insurance)

AUTOMOBILE INSURANCE COVERAGE

AN ACT to amend and reenact section 26-34-01 of the North Dakota Century Code, relating to the establishment of primary and excess automobile liability coverages in certain instances.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26-34-01 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-34-01. Establishment of primary and excess automobile liability coverages in certain instances. When an automobile ~~liability~~ insurance policy, which for the purposes of this chapter includes only automobile liability coverage, uninsured motorist coverage, automobile medical payments coverage and basic or optional excess no-fault benefits, is in force for anyone engaged in the business of selling, repairing, servicing, storing, leasing, or parking motor vehicles and the owner of said vehicles loans, rents, or leases a vehicle to any other person or organization and the vehicle is involved in an accident out of which bodily injury or property damage arises, the following automobile insurance policies shall be applicable:

1. In the event no other automobile ~~liability~~ insurance policy is in force at the time of the accident for the person or organization to whom the vehicle was loaned, rented, or leased, the coverage provided by the motor vehicle owner's automobile ~~liability~~ policy shall extend to the borrower, rentee, or lessee in the event the owner's automobile ~~liability~~ insurance policy extends coverage to said borrower, rentee, or lessee.

2. In the event that another automobile ~~liability~~ insurance policy is in force for the person or organization to whom the vehicle was loaned, rented, or leased, any coverage provided by the motor vehicle owner's automobile ~~liability~~ insurance policy shall be excess coverage only but limited, however, by the terms of the owner's applicable automobile ~~liability~~ insurance policy. The ~~limits of liability in the~~ policy afforded the person or organization to whom the vehicle was loaned, rented, or leased shall be primary.

Approved March 4, 1983

CHAPTER 329

SENATE BILL NO. 2499
(Todd, Tallackson)
(Approved by the Committee on Delayed Bills)

INSURANCE GUARANTY ASSOCIATION

AN ACT to establish a life and health insurance guaranty association.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. **Scope.** This Act applies to direct life insurance policies, accident and sickness insurance policies, annuity contracts, and contracts supplemental to life and accident and sickness insurance policies, health service contracts, annuity contracts, and contracts supplemental to life and accident and sickness insurance policies and annuity contracts issued by persons licensed to transact insurance in this state at any time. This Act does not apply to:

1. That portion or part of a variable life insurance or variable annuity contract not guaranteed by an insurer.

2. That portion or part of any policy or contract under which the risk is borne by the policyholder.

3. Any policy or contract or part thereof assumed by the impaired or insolvent insurer under a contract of reinsurance, other than reinsurance for which assumption certificates have been issued.

4. Any such policy or contract issued by a health maintenance organization, a fraternal benefit society, a benevolent society, or the comprehensive health association.

SECTION 2. **Definitions.** As used in this Act:

1. "Account" means either of the three accounts created under section 3.

2. "Association" means the North Dakota life and health insurance guaranty association.

3. "Commissioner" means the commissioner of insurance.

4. "Contractual obligation" means any obligation under covered policies.

5. "Covered policy" means any policy or contract within the scope of this Act under section 1.

6. "Impaired insurer" means a member insurer deemed by the commissioner after the effective date of this Act to be potentially unable to fulfill its contractual obligations and not an insolvent insurer.

7. "Insolvent insurer" means a member insurer which after the effective date of this Act, becomes insolvent and is placed under a final order of liquidation, rehabilitation, or conservation by a court of competent jurisdiction.

8. "Member insurer" means any person licensed to transact in this state any kind of insurance to which this Act applies under section 1.

9. "Premiums" means direct gross insurance premiums, subscriber fees, and annuity considerations received on covered policies, less return premiums and considerations thereon and dividends paid or credited to policyholders on such direct business. "Premiums" do not include premiums and considerations on contracts between insurers and reinsurers.

10. "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.

SECTION 3. Creation of the North Dakota life and health insurance guaranty association - Accounts - Supervision by commissioner. There is created a nonprofit legal entity to be known as the North Dakota life and health insurance guaranty association. All member insurers shall be and remain members of the association as a condition of their authority to transact insurance in this state. The association shall perform its functions under its plan of operation and shall exercise its powers through a board of directors. For purposes of administration and assessment, the association shall maintain a health insurance account, a life insurance account, and an annuity account. The association is under the supervision of the commissioner and is subject to the applicable provisions of this title.

SECTION 4. Board of directors. The board of directors of the association must consist of not less than five nor more than nine member insurers serving terms as established in the plan of operation. The member insurers shall select the members of the board, subject to the approval of the commissioner. 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. To select the initial board of directors, and initially organize the association, the commissioner shall give notice to all member insurers of the time and place of the organizational meeting. In determining voting rights at the organizational meeting each member insurer is entitled to one vote in person or by proxy. If the board of directors is not selected within sixty days after notice of the organizational meeting, the commissioner may appoint the initial members. In approving selections or in appointing members to the board, the commissioner shall consider, among other things, whether all member insurers are fairly represented. Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors but members of the board may not otherwise be compensated by the association for their services.

SECTION 5. Powers, duties, and authority of the association. In addition to the powers and duties enumerated in other sections of this Act:

1. If a domestic insurer is an impaired insurer, the association may, subject to any conditions imposed by the association other than those which impair the contractual obligations of the impaired insurer, and approved by the impaired insurer and the commissioner:

   a. Guarantee or reinsure, or cause to be guaranteed, assumed, or reinsured, any or all of the covered policies of the impaired insurers.

   b. Provide any moneys, pledges, notes, guarantees, or other means as are proper to effectuate subdivision a, and assure payment of the contractual obligations of the impaired insurer pending action under subdivision a.

   c. Loan money to the impaired insurer.

2. If a domestic insurer is an insolvent insurer, the association shall, subject to the approval of the commissioner:

   a. Guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured the covered policies of the insolvent insurer.

   b. Assure payment of the contractual obligations of the insolvent insurer.

   c. Provide any moneys, pledges, notes, guarantees, or other means as are reasonably necessary to discharge duties under subdivisions a and b.

3. If a foreign or alien insurer is an insolvent insurer, the association shall, subject to the approval of the commissioner:

   a. Guarantee, assume, or reinsure or cause to be guaranteed, assumed, or reinsured the covered policies of residents.

   b. Assure payment of the contractual obligations of the insolvent insurer to residents.

   c. Provide any moneys, pledges, notes, guarantees, or other means as are reasonably necessary to discharge duties under subdivisions a and b.

   This subsection does not apply where the commissioner has determined that the foreign or alien insurer's domiciliary jurisdiction or state of entry provides, by statute, protection substantially similar to that provided by this Act for residents of this state.

4. In carrying out its duties under subsections 2 and 3, permanent policy liens or contract liens may be imposed in connection with any guarantee, assumption or reinsurance agreement, if the court:

   a. Finds that the amounts which can be assessed under this Act are less than the amounts needed to assure full and prompt performance of the insolvent insurer's contractual obligations, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of policy or contract liens, to be in the public interest; and

   b. Approves the specific policy liens or contract liens to be used.

   Before being obligated under subsections 2 and 3, the association may request that there be imposed temporary moratoriums or liens on payments of cash values and policy loans in addition to any contractual provisions for deferral of cash or policy loan values, and such temporary moratoriums and liens may be imposed if they are approved by the court.

5. If the association fails to act within a reasonable period of time as provided in subsections 2 and 3, the commissioner shall have the powers and duties of the association under this Act with respect to insolvent insurers.

6. The association may render assistance and advice to the commissioner, upon the commissioner's request, concerning

rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of any impaired or insolvent insurer.

7. The association may appear before any court in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this Act. This standing extends to all matters germane to the powers and duties of the association, including proposals for reinsuring or guaranteeing the covered policies of the impaired or insolvent insurer and the determination of the covered policies and contractual obligations.

8. Any person receiving benefits under this Act is deemed to have assigned the rights under the covered policy to the association to the extent of the benefits received because of this Act whether the benefits are payments of contractual obligations or continuation of coverage. The association may require an assignment to it of such rights by any payee, policy or contract owner, beneficiary, insured, or annuitant as a condition precedent to the receipt of any rights or benefits conferred by this Act upon that person. The association is subrogated to these rights against the assets of any insolvent insurer. The subrogation rights of the association under this subsection have the same priority against the assets of the insolvent insurer as that possessed by the person entitled to receive benefits under this Act.

9. The contractual obligations of the insolvent insurer for which the association becomes or may become liable are as great as but no greater than the contractual obligations of the insolvent insurer would have been in the absence of an insolvency unless the obligations are reduced as permitted by subsection 4 but the aggregate liability of the association may not exceed one hundred thousand dollars in cash values, or three hundred thousand dollars for all benefits, including cash values, with respect to any one life.

10. The association may:

    a. Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this Act.

    b. Sue or be sued, including taking any legal actions necessary or proper for recovery of any unpaid assessments under section 6.

    c. Borrow money to effect the purposes of this Act. Any notes or other evidence of indebtedness of the association not in default are legal investments for

domestic 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 any other functions as become necessary or proper under this Act.

e. Negotiate and contract with any liquidator, rehabilitator, conservator, or ancillary receiver to carry out the powers and duties of the association.

f. Take any necessary legal action to avoid payment of improper claims.

g. Exercise, for the purposes of this Act and to the extent approved by the commissioner, the powers of a domestic life or accident and sickness insurer, but the association may not issue insurance policies or annuity contracts other than those issued to perform the contractual obligations of the impaired or insolvent insurer.

SECTION 6. Assessments.

1. For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each account, at such time and for such amounts as the board finds necessary. Assessments are due not less than thirty days after prior written notice to the member insurers and shall accrue interest at eighteen percent per annum on and after the due date.

2. There are three classes of assessments:

a. Class A assessments are made for the purpose of meeting administrative costs and other general expenses and examinations conducted under the authority of subsection 5 of section 9 not related to a particular impaired or insolvent insurer.

b. Class B assessments are made to the extent necessary to carry out the powers and duties of the association under section 5 with regard to an impaired or insolvent domestic insurer.

c. Class C assessments are made to the extent necessary to carry out the powers and duties of the association under section 5 with regard to an insolvent foreign or alien insurer.

3. a. The board shall determine the amount of any class A assessment. The assessment may be made on a non-pro

rata basis. The assessment must be credited against future insolvency assessments and may not exceed fifty dollars per company in any one calendar year. The amount of any class B or class C assessment must be allocated for assessment purposes among the accounts in the proportion that the premiums received by the impaired or insolvent insurer on the policies covered by each account for the last calendar year preceding the assessment in which the impaired or insolvent insurer received premiums bears to the premiums received by such insurer for such calendar year on all covered policies.

b. Class C assessments against member insurers for each account must be in the proportion that the premiums received on business in this state by each assessed member insurer on policies covered by each account for the calendar year preceding the assessments bears to such premiums received on business in this state for the calendar year preceding the assessment by all assessed member insurers.

c. Class B assessments for each account must be made separately for each state in which the impaired or insolvent domestic insurer was authorized to transact insurance at any time, in the proportion that the premiums received on business in that state by the impaired or insolvent insurer on policies covered by the account for the last calendar year preceding the assessment in which the impaired or insolvent insurer received premiums bears to the premiums received in all such states for that calendar year by the impaired or insolvent insurer. The assessments against member insurers must be in the proportion that the premiums received on business in each such state by each assessed member insurer on policies covered by each account for the calendar year preceding the assessment bears to such premiums received on business in each state for the calendar year preceding assessment by all assessed member insurers.

d. Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer may not be made until necessary to implement the purposes of this Act. Classification of assessments under subsection 2 and computation of assessments under this subsection must be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible.

4. The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual

obligations. If an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section.

5. The total of all assessments upon a member insurer for each account may not in any one calendar year exceed two percent of the insurer's premiums received in this state during the calendar year preceding the assessment on the policies covered by the account. If the maximum assessment, together with the other assets of the association in either account, does not provide in any one year in either account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds must be assessed as soon thereafter as permitted by this Act.

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

7. The association shall issue to each insurer paying an assessment under this Act, other than a class A assessment, a certificate of contribution, in a form prescribed by the commissioner, for the amount of the assessment paid. All outstanding certificates are of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the commissioner may approve.

SECTION 7. Plan of operation.

1. The association shall submit to the commissioner a plan of operation and any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments become effective upon approval in writing by the commissioner. If the association fails to submit a suitable plan of operation within one hundred eighty days following the effective date of this Act or if at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall, after

notice and hearing, adopt any reasonable rules necessary or advisable to effectuate the provisions of this Act. The rules must continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

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

3. The plan of operation shall, in addition to requirements enumerated elsewhere in this Act:

   a. Establish procedures for handling the assets of the association.

   b. Establish the amount and method of reimbursing members of the board of directors under section 4.

   c. Establish regular places and times for meetings of the board of directors.

   d. Establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors.

   e. Establish the procedures whereby selections for the board of directors will be made and submitted to the commissioner.

   f. Establish any additional procedures for assessments under section 6.

   g. Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

4. The plan of operation may provide that any or all powers and duties of the association, except those under subdivision c of subsection 10 of section 5 and section 6, are 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 must be reimbursed for any payments made on behalf of the association and must be paid for its performance of any function of the association. A delegation under this subsection takes 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 by this Act.

SECTION 8. **Powers and duties of the commissioner.** In addition to the duties and powers enumerated elsewhere in this Act,

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.

   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 constitutes notice to its shareholders, if any. The failure of the insurer to promptly comply with this demand does not excuse the association from the performance of its powers and duties under this Act.

   c. In any liquidation or rehabilitation proceeding involving a domestic insurer, be appointed as the liquidator or rehabilitator. If a foreign or alien member insurer is subject to a liquidation proceeding in its domiciliary jurisdiction or state of entry, the commissioner shall be appointed conservator.

2. The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative the commissioner may levy a forfeiture on any member insurer which fails to pay an assessment when due. Such forfeiture may not exceed five percent of the unpaid assessment per month, but no forfeiture may be less than one hundred dollars per month.

3. Any action of the board of directors or the association may be appealed to the commissioner by any member insurer within thirty days of the action being appealed.

4. The liquidator, rehabilitator, or conservator of any impaired insurer may notify all interested persons of the effect of this Act.

SECTION 9. **Prevention of insolvencies.** To aid in the detection and prevention of insurer insolvencies or impairments:

1. The commissioner shall:

   a. Notify the commissioners of all the other states when the commissioner takes any of the following actions against a member insurer:

      (1) Revocation of license.

(2) Suspension of license.

(3) Issuance of any formal order that the company restrict its premium writing, obtain additional contributions to surplus, withdraw from the state, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of policyholders or creditors.

The notice shall be mailed to all commissioners within thirty days following the action taken or the date on which such action occurs.

b. Report to the board of directors when the commissioner has taken any of the actions set forth in subdivision a or has received a report from any other commissioner indicating that any such action has been taken in another state. The report to the board of directors must contain all significant details of the action taken or the report received from another commissioner.

c. Report to the board of directors when the commissioner has reasonable cause to believe from any examination, whether completed or in process, of any member company that the company may be an impaired or insolvent insurer.

d. Furnish to the board of directors the early warning tests developed by the national association of insurance commissioners, and the board may use the information contained therein in carrying out its duties and responsibilities under this section. The board of directors shall keep the report and the information contained in the report confidential until such time as made public by the commissioner or other lawful authority.

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

3. The board of directors may, upon majority vote, make reports and recommendations to the commissioner upon any manner germane to the solvency, liquidation, rehabilitation, or conservation of any member insurer or germane to the solvency of any company seeking to do an insurance business in this state. The reports and recommendations are not public documents.

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

5. The board of directors may, upon majority vote, request that the commissioner order an examination of any member insurer which the board in good faith believes may be an impaired or insolvent insurer. Within thirty days of the receipt of the request, the commissioner shall begin the examination. The examination may be conducted as a national association of insurance commissioners examination or may be conducted by any persons the commissioner designates. The association shall pay the cost of the examination, and the examination report shall be treated as are other examination reports. The examination report may not be released to the board of directors prior to its release to the public, but this does not preclude the commissioner from complying with subsection 1. The commissioner shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the commissioner but,it is not open to public inspection prior to the release of the examination report to the public.

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

7. The board of directors shall, at the conclusion of any insurer insolvency in which the association was obligated to pay covered claims, prepare a report to the commissioner containing the information it may have in its possession bearing on the history and causes of the insolvency. The board shall cooperate with the boards of directors of guaranty associations in other states in preparing a report on the history and causes for insolvency of a particular insurer, and may adopt by reference any report prepared by the other associations.

SECTION 10. Credits for assessments paid.

1. A member insurer may offset against its premium or income tax liability to this state an assessment described in subsection 8 of section 6 to the extent of twenty percent of the amount of the assessment for each of the five calendar years following the year in which the assessment was paid. If a member insurer ceases doing business, all uncredited assessments may be credited against its premium or income tax liability for the year it ceases doing business.

2. The association shall pay any sums acquired by refund, pursuant to subsection 6 of section 6, from the association which have theretofore been written off by

contributing insurers and offset against premium or income taxes as provided in subsection 1, and are not then needed for purposes of this Act, to the commissioner. The commissioner shall deposit these sums with the state treasurer for credit to the general fund of this state.

SECTION 11. Assessment liability - Recordkeeping - Obligations - Distributions.

1. This Act does not reduce the liability for unpaid assessments of the insureds on an impaired or insolvent insurer operating under a plan with assessment liability.

2. Records shall be kept of all negotiations and meetings in which the association or its representatives are involved to discuss the activities of the association in carrying out its powers and duties under section 5. Records of the negotiations or meetings may be made public only upon the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer, upon the termination of the impairment of insolvency of the insurer, or upon the order of a court of competent jurisdiction. This subsection does not limit the duty of the association to render a report of its activities under section 12.

3. For the purpose of carrying out its obligations under this Act, the association is deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the association is entitled as subrogee pursuant to subsection 8 of section 5. Assets of the impaired or insolvent insurer attributable to covered policies must be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this Act. Assets attributable to covered policies, as used in this subsection, is that proportion of the assets which the reserves that should have been established for such policies bear to the reserves that should have been established for all policies of insurance written by the impaired or insolvent insurer.

4. a. Prior to the termination of any liquidation, rehabilitation, or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders and policyowners of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of such insolvent insurer. In the determination consideration must be given to the welfare of the policyholders of the continuing or successor insurer.

b. No distribution to stockholders, if any, of an impaired or insolvent insurer may be made until and unless the total amount of valid claims of the association for funds expended in carrying out its powers and duties under section 5 with respect to the insurer have been fully recovered by the association.

5. a. If an order for liquidation or rehabilitation of an insurer domiciled in this state has been entered, the receiver appointed under such order shall have a right to recover on behalf of the insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the insurer on its capital stock, made at any time during the five years preceding the petition for liquidation or rehabilitation subject to the limitations of sudivisions b through d. As used in this subsection, "affiliate" and "control" have the meanings contained in section 26.1-10-01.

b. No such dividend is recoverable if the insurer shows that when paid the distribution was lawful and reasonable, and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

c. Any person who was an affiliate that controlled the insurer at the time the distributions were paid is liable up to the amount of distributions that person received. Any person who was an affiliate that controlled the insurer at the time the distributions were declared, is liable up to the amount of distributions that person would have received if they had been paid immediately. If two persons are liable with respect to the same distributions, they are jointly and severally liable.

d. The maximum amount recoverable under this subsection is the amount needed in excess of all other available assets of the insolvent insurer to pay the contractual obligations of the insolvent insurer.

e. If any person liable under subdivision c is insolvent, all its affiliates that controlled it at the time the dividend was paid are jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

SECTION 12. **Examination of the association - Annual statement.** The association is subject to examination and regulation by the commissioner. The board of directors shall submit to the commissioner, not later than March first of each year, a financial report for the preceding calendar year in a form approved by the

commissioner and a report of its activities during the preceding calendar year.

SECTION 13. **Tax exemptions.** The association is exempt from payment of all fees and all taxes levied by this state or any of its subdivisions, except taxes levied on real property.

SECTION 14. **Immunity.** There is no liability on the part of and no cause of action of any nature may arise against any member insurer or its agents or employees, the association or its agents or employees, members of the board of directors, or the commissioner or the commissioner's representatives, for any action taken by them in the performance of their powers and duties under this Act.

SECTION 15. **Stay of proceedings; Reopening default judgments.** All proceedings in which the insolvent insurer is a party in any court in this state must be stayed sixty days from the date an order of liquidation, rehabilitation, or conservation is final to permit proper legal action by the association on any matters germane to its powers or duties. As to judgment under any decision, order, verdict, or finding based on default, the association may apply to have the judgment set aside by the same court that made the judgment and shall be permitted to defend against such suit on the merits.

SECTION 16. **Prohibited advertisement of Act in insurance sales.** No person, including an insurer, agent, or affiliate of an insurer may make, publish, disseminate, circulate, or place before the public, or cause directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in any newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio station or television station, or in any other way, any advertisement, announcement or statement which uses the existence of the association for the purpose of sales, solicitation, or inducement to purchase any form of insurance covered by this Act. This section does not apply to the association or any other entity which does not sell or solicit insurance.

Approved April 14, 1983

CHAPTER 330

HOUSE BILL NO. 1195
(Committee on Industry, Business, and Labor)
(At the request of the Commissioner of Insurance)

STACKING OF MOTOR VEHICLE LIABILITY BENEFITS

AN ACT to create and enact a new section to chapter 26-41 of the North Dakota Century Code, relating to the Automobile Reparations Act; and to amend and reenact section 26-02-42 of the North Dakota Century Code, relating to uninsured motorist coverage.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Section 26-02-42 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-02-42. Uninsured motorist coverage - Compulsory - Stacking not permitted.

1. No motor vehicle liability policy of insurance against loss resulting from liability imposed by law for bodily injury or death suffered by any person arising out of ownership, maintenance, or use of any motor vehicle shall be delivered or issued for delivery in this state with respect to any motor vehicle registered or principally garaged in this state unless coverage is provided therein or supplemental thereto in amounts not less than that set forth in section 39-16.1-11 for bodily injury or death, for the protection of persons insured thereunder who are legally entitled to recover damages from owners or operators of uninsured motor vehicles and hit-and-run motor vehicles because of bodily injury, sickness or disease, including death, resulting therefrom.

2. Any motor vehicle liability policy of insurance which provides uninsured motorist coverage, as specified in subsection 1, must provide that an insured or named insured is only protected to the extent of the coverage provided on the vehicle covered by such policy and involved in the accident. If no such vehicle is involved, coverage is only available to the extent of the applicable uninsured motorist coverage provided on any one of the

insured or named insured's vehicles. In either instance, coverage on any other vehicle may not be added or stacked upon the applicable coverage.

SECTION 2. A new section to chapter 26-41 of the North Dakota Century Code is hereby created and enacted to read as follows:

Stacking of basic no-fault benefits prohibited. When an injured person is provided basic no-fault benefits by an insurance policy issued in compliance with this chapter, the injured person is covered only to the extent of the basic no-fault benefits provided on the secured motor vehicle involved in the accident. If any person is injured while occupying an unsecured motor vehicle, basic no-fault benefits are only available to the extent of the applicable basic no-fault benefits provided to the injured person as the owner of a secured motor vehicle or as a relative of the owner of a secured motor vehicle. In either instance, basic no-fault benefits on any secured motor vehicle may not be added or stacked upon basic no-fault benefits available from any other source.

Approved March 3, 1983

CHAPTER 331

HOUSE BILL NO. 1194
(Committee on Industry, Business, and Labor)
(At the request of the Commissioner of Insurance)

ASSIGNED CLAIMS PLAN

AN ACT to amend and reenact subsection 1 of section 26-41-19 of the North Dakota Century Code, relating to the assigned claims plan.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. AMENDMENT. Subsection 1 of section 26-41-19 of the 1981 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

1. Basic no-fault insurers authorized to provide basic no-fault benefits in this state are hereby directed to organize, participate in, and maintain an assigned claims plan to provide that an injured person who suffers economic loss and is eligible for basic no-fault benefits under section 26-41-07, other than a person not entitled to benefits under section 26-41-08, may obtain basic no-fault benefits through said plan if:

   a. Basic no-fault benefits are not applicable to the injury for some reason other than those specified in section 26-41-08; or

   b. Basic no-fault benefits applicable to the injury are inadequate to provide the contracted-for benefits because of financial inability of a basic no-fault insurer to fulfill its obligations. Payments made by the assigned claims plan pursuant to this subsection shall constitute covered claims under the North Dakota Insurance Guaranty Association Act.

Approved March 3, 1983

CHAPTER 332

HOUSE BILL NO. 1054
(Legislative Council)
(Interim Insurance Code Revision Committee)

INSURANCE CODE REVISION

AN ACT to create and enact chapters 26.1-01, 26.1-02, 26.1-03, 26.1-04, 26.1-05, 26.1-06, 26.1-07, 26.1-08, 26.1-09, 26.1-10, 26.1-11, 26.1-12, 26.1-13, 26.1-14, 26.1-15, 26.1-16, 26.1-17, 26.1-18, 26.1-19, 26.1-20, 26.1-21, 26.1-22, 26.1-23, 26.1-24, and 26.1-25 of the North Dakota Century Code, relating to the commissioner of insurance; insurance company general provisions, examinations and reports and the premium tax, prohibited practices, organization and operation, takeover bids, and consolidation, reinsurance, and dissolution; comprehensive health association; reciprocal or interinsurance exchanges; insurance holding company systems; foreign insurance companies; incorporated mutual companies; county mutual insurance companies; medical malpractice mutual insurance company; fraternal benefit societies; benevolent societies; nonprofit health service corporations; health maintenance organizations; prepaid legal service organizations; title insurance companies; state bonding fund; state fire and tornado fund; state unsatisfied judgment fund; the insurance premium; and fire, property, and casualty insurance rates; to repeal sections 6-05-19, 6-05-20, 6-05-21, 6-05-22, 6-05-23, 6-05-24, 6-05-30, 6-05-31, 6-05-32, 6-05-33, chapters 26-01 and 26-04, section 26-05-03, chapters 26-07, 26-08, 26-09, 26-09.1, sections 26-10-02, 26-10-03, 26-10-04, 26-10-05, 26-10-09, 26-10-10, 26-10-11, 26-10-13.1, 26-10-14, 26-10-15, 26-10-16, chapters 26-11, 26-12, 26-14, 26-15, 26-16, 26-16.1, sections 26-17.1-50, 26-17.1-51, 26-17.1-52, 26-17.1-53, 26-18-01, 26-18-02, 26-18-12, chapters 26-20, 26-21, 26-21.1, 26-21.2, 26-23, 26-24, 26-25, 26-26, 26-27, 26-27.1, 26-27.2, 26-27.3, 26-28, 26-29, 26-30, 26-32, 26-37, 26-38, 26-40, and 39-17 of the North Dakota Century Code, relating to insurance; to provide penalties; to provide for transition; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. Chapter 26.1-01 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-01-01. "Commissioner" defined. Unless the context or subject matter otherwise requires, in this title the word "commissioner" means the commissioner of insurance.

26.1-01-02. Commissioner - Seal - Employment of deputy and assistants. The commissioner shall have an official seal and shall keep an impression of the seal on file in the office of the secretary of state. The commissioner shall employ a deputy and other competent officials and clerks to discharge the duties assigned by the commissioner. When the commissioner is absent temporarily from the office, the deputy commissioner may sign the commissioner's name and perform any other statutory duties pertaining to the office.

26.1-01-03. Duties of commissioner. The commissioner shall:

1. See that all the laws of this state respecting insurance companies and benevolent societies are executed faithfully.

2. Report in detail to the attorney general any violation of law relative to insurance companies and their officers or agents.

3. File the articles of incorporation of all insurance companies organized or doing business in this state, and on application furnish a certified copy thereof.

4. Furnish the insurance companies required to make reports to the commissioner and the benevolent societies the necessary blank forms for required statements and reports. The commissioner is not required to send blank forms to those insurance companies which submit their reports on printed forms conforming to those furnished by the commissioner.

5. Preserve in permanent form a full record of the commissioner's proceedings and a concise statement of each company or agency visited or examined.

6. Furnish at the request of any person, upon the payment of the required fee, certified copies of any record or paper in the commissioner's office, if the commissioner deems it not prejudicial to the public interests to do so, and give such other certificates as may be provided by law.

7. Submit a biennial report as prescribed by section 54-06-04 to the governor and the office of management and budget. In addition to the requirements of section 54-06-04, the report must contain an abstract only of the reports of the various insurance companies doing business in this state showing the condition of the companies.

8. Send a copy of the commissioner's annual report to the insurance commissioner, or other similar officer, of every

other state and to each company doing business in this state.

9. Communicate, on request, to the insurance commissioner of any other state any facts which by law it is the commissioner's duty to ascertain respecting companies of this state doing business within that state.

10. Manage, control, and supervise the state bonding fund.

11. Manage, control, and supervise the state fire and tornado fund and the insurance of public buildings in that fund.

26.1-01-04. Service of process upon commissioner - Procedure. Where a consent to service of any process, notice, order, or demand upon the commissioner is provided under this title, the service is to be in duplicate. The commissioner immediately shall forward one copy by registered mail to the person against whom the process, notice, order, or demand is directed at that person's last reasonably ascertainable address and shall file the other copy in the office of the commissioner. The person serving process upon the commissioner shall pay the fee provided in section 26.1-01-07. The commissioner shall keep a record of the date and hour of service.

26.1-01-05. Reporting and review of medical malpractice claims, settlements, and judgments.

1. A health care provider or the insurer of a health care provider, if any, shall report all claims, settlements of claims, or final judgments against the health care provider to the commissioner. The report must be made in the manner prescribed by the commissioner and must provide those facts the commissioner deems necessary to gather adequate information regarding claims, settlements of claims, and final judgments against health care providers. For the purposes of this section, a "health care provider" includes any person, corporation, facility, or institution licensed by this state to provide health care or professional services as a physician, hospital, dentist, professional or practical nurse, physician's aide, optometrist, podiatrist, chiropractor, physical therapist, or psychologist, or an officer, employee, or agent thereof acting in the course and scope of employment.

2. The commissioner shall forward copies of all reports required by this section to the appropriate board of professional registration, examination, or licensure. That board shall review all reports which it receives and may take any necessary disciplinary action against a health care provider where the action is appropriate, including censure, imposition of probation, or suspension or revocation of the health care provider's license. The board shall conduct the review as an administrative

hearing in the manner provided in chapter 28-32, including the giving of appropriate notice.

26.1-01-06. Reporting of statistical data regarding legal malpractice claims, settlements, and judgments. The insurer of an attorney shall report statistical data regarding all claims, settlements of claims, or final judgments against the attorney to the commissioner. The report must be made in the manner prescribed by the commissioner and must provide those facts the commissioner deems necessary to gather adequate information regarding claims, settlements of claims, and final judgments against attorneys except that the commissioner may not require the insurer to provide the names of the parties involved in these claims.

26.1-01-07. Fees chargeable by commissioner. The commissioner shall charge and collect the following fees:

1. For filing articles of incorporation, or copies, or amendments thereof, twenty-five dollars.

2. For each original certificate of authority issued upon admittance, fifty dollars and for renewal of certificate of authority, amendment to certificate of authority, or certified copy thereof, twenty-five dollars.

3. For issuing an annual reciprocal exchange license, the same fees as those applicable to the issuance of a certificate of authority in subsection 2.

4. For filing an annual report of a fraternal benefit society, and issuing a license or permit to the society, and for each renewal thereof, twenty-five dollars.

5. For filing bylaws or amendments thereof, five dollars.

6. For filing of articles of merger, or copies thereof, thirty dollars.

7. For receiving the service of process as attorney, whether the commissioner is served with the process or admits service thereon, two dollars.

8. For filing of power of attorney by nonadmitted insurer for conduct of business in compliance with surplus lines laws of this state, ten dollars.

9. For filing an annual statement, twenty-five dollars.

10. For each abstract of the annual statement of an insurance company for publication, three dollars.

11. For an official examination, the actual expense and per diem incurred; but the per diem charge may not exceed thirty-five dollars.

12. For issuing a certificate to a domestic insurance company showing a compliance with the compulsory reserve provisions of this title and the maintenance of proper security deposits, and for any renewal of the certificate, five dollars.

13. For a written licensee's examination administered by the office of the commissioner, with the examination not to exceed two lines of insurance at any one sitting, twenty dollars.

14. For a written licensee's examination not administered by the office of the commissioner under a contract with a testing service, the actual cost of the examination, subject to approval of the commissioner, which shall be paid to the testing service.

15. For issuing a resident insurance broker's, surplus lines insurance broker's and insurance consultant's license, or duplicate thereof, ten dollars.

16. For issuing a nonresident insurance broker's, surplus lines insurance broker's and insurance consultant's license, or duplicate thereof, fifteen dollars.

17. For issuing a license for a resident agent or limited insurance representative of a foreign insurance company, or duplicate, three dollars.

18. For issuing a nonresident insurance agent's or limited insurance representative's license, or duplicate, ten dollars.

19. For issuing a license for an agent or limited insurance representative of a domestic insurance company, county mutual insurance company, fraternal benefit society, or any other society, or duplicate, three dollars.

20. For issuing a license to a resident agent for the attorney for a reciprocal exchange, three dollars.

21. For filing of any miscellaneous documents or papers, including documents of admission and those filed annually upon license renewal, one dollar each.

22. For a copy of any paper filed in the commissioner's office, twenty cents per folio.

23. For affixing the commissioner's official seal on a copy of any paper filed in the office and certifying the copy, one dollar.

Nonprofit health service corporations and health maintenance organizations are subject to the same fees as any other insurance

company. County mutual insurance companies and benevolent societies are liable only for the fees mentioned in subsections 2, 10, 11, 13, 19, 22, and 23.

26.1-01-08. Rulemaking - Administrative procedure - Appeal from commissioner's decision. Any rulemaking or any administrative proceeding conducted by the commissioner is subject to chapter 28-32, and any order or decision of the commissioner, unless otherwise specifically provided for by law, is subject to review or appeal in the manner provided by chapter 28-32.

26.1-01-09. Salary of commissioner. The annual salary of the commissioner is thirty-three thousand five hundred dollars.

26.1-01-10. General penalty. For a violation of any provision of this title, when no penalty is provided specifically, the offender is guilty of an infraction.

SECTION 2. Chapter 26.1-02 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-02-01. Definitions. In chapters 26.1-02 through 26.1-04, unless the context or subject matter otherwise requires:

1. "Domestic" means incorporated or formed in this state.

2. "Foreign", when used without limitation, means formed by the authority of any state or government other than this state.

3. "Foreign decree" means any decree or order in equity of a court located in a reciprocal state, including a court of the United States, against any insurer incorporated or authorized to do business in this state.

4. "Insurance company" includes any corporation, association, benefit society, exchange, partnership, or individual engaged as principal in the business of insurance.

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

6. "Reciprocal state" means any state the laws of which contain procedures substantially similar to those specified in this chapter for the enforcement of decrees or orders in equity issued by courts located in other states, against any insurance company incorporated or authorized to do business in that state.

26.1-02-02. Duty of commissioner before granting or renewing certificate of authority. The commissioner must be satisfied by examination and evidence that an insurance company is legally qualified to transact business in this state, including compliance with section

26.1-03-11, before granting a certificate of authority to the company to issue policies or make contracts of insurance. A certificate of authority issued under this title remains in force in perpetuity if the required renewal fee is paid and the commissioner is satisfied that the documents required by section 26.1-03-11 have been filed, the statements and evidences of investment required of the company have been furnished, the required capital or surplus or both, securities, and investments remain secure, and all other requirements of law are met.

26.1-02-03. Inquiry into condition of company. The commissioner may address to any insurance company doing or applying for permission to do business in this state any inquiries in relation to its activities, condition, or any other matter connected with its transactions. The company must reply to the inquiries promptly and in writing.

26.1-02-04. Company controlled by foreign government prohibited - Penalty. An insurance company or other insurance entity financially owned or financially controlled by any foreign government outside the United States may not do any insurance business in this state. The commissioner may not grant a license or issue a certificate of authority to any insurance company or other insurance entity financially owned or financially controlled by any foreign government outside the United States to transact any insurance business in this state. This section does not affect any insurance company qualified to do business in this state before January 2, 1955.

26.1-02-05. Unauthorized insurance prohibited - Exceptions. An insurance company may not transact insurance business in this state, as set forth in section 26.1-02-06, without a certificate of authority from the commissioner. This section does not apply to:

1. The lawful transaction of surplus lines insurance.

2. The lawful transaction of reinsurance by insurers.

3. Transactions involving a policy lawfully solicited, written, and delivered outside of this state covering only subjects of insurance not resident, located, or expressly to be performed in this state at the time of issuance, and which transactions are subsequent to the issuance of such policy.

4. Transactions involving life insurance, health insurance, or annuities provided to educational or religious or charitable institutions organized and operated without profit to any private shareholder or individual, for the benefit of the institutions and individuals engaged in the service of the institutions.

5. Attorneys acting in the ordinary relation of attorney and client in the adjustment of claims or losses.

6. Transactions involving group life, sickness, and accident, or blanket sickness and accident insurance, or group annuities where the master policy of the group was lawfully issued and delivered in and pursuant to the laws of a state in which the insurance company was authorized to do an insurance business, to a group organized for purposes other than the procurement of insurance, and where the policyholder is domiciled or otherwise has a bona fide situs.

7. Transactions involving any policy of insurance or annuity contract issued before July 1, 1973.

8. Transactions relative to a policy issued or to be issued outside this state involving insurance on vessels, craft or hulls, cargoes, marine builder's risk, marine protection and indemnity or other risk, including strikes and war risks commonly insured under ocean or wet marine forms of policy.

9. Transactions involving contracts of insurance issued to one or more industrial insureds; provided, that this does not relieve an industrial insured from taxation imposed upon independently procured insurance. An industrial insured is an insured:

   a. Which procures the insurance of any risk or risks other than life and annuity contracts by use of the services of a full-time employee acting as an insurance manager or buyer or the services of a regularly and continuously retained qualified insurance consultant;

   b. Whose aggregate annual premiums for insurance on all risks total at least twenty-five thousand dollars; and

   c. Which has at least twenty-five full-time employees.

26.1-02-06. Insurance transactions defined - Venue. Any of the following acts in this state effected by mail or otherwise by or on behalf of an unauthorized insurance company constitutes the transaction of an insurance business in this state:

1. Making or proposing to make, as an insurance company, an insurance contract.

2. Making or proposing to make, as guarantor or surety, any contract of guaranty or suretyship as a vocation and not merely incidental to any other legitimate business or activity of the guarantor or surety.

3. Taking or receiving of any application for insurance.

4. Receiving or collecting any premium, commission, membership fees, assessments, dues, or other consideration for any insurance or any part thereof.

5. Issuing or delivering a contract of insurance to residents of this state or to persons authorized to do business in this state.

6. Directly or indirectly acting as an agent for or otherwise representing or aiding on behalf of another, any person or insurance company in the solicitation, negotiation, procurement, or effectuation of insurance or renewals thereof or in the dissemination of information as to coverage or rates, or forwarding of applications, or delivery of policies or contracts, or inspection of risks, or fixing of rates, or investigation or adjustment of claims or losses, or in the transaction of matters subsequent to effectuation of the contract and arising out of it, or in any other manner representing or assisting a person or insurance company in the transaction of insurance with respect to subjects of insurance resident, located, or to be performed, in this state. This subsection does not prohibit full-time salaried employees of a corporate insured from acting in the capacity of an insurance manager or buyer in placing insurance on behalf of the employer.

7. Transacting any kind of insurance business specifically recognized as transacting an insurance business within the meaning of the statutes relating to insurance.

8. Transacting or proposing to transact any insurance business in substance equivalent to any of the foregoing in a manner designed to evade these statutes.

The venue of an act committed by mail is at the point where the matter transmitted by mail is delivered and takes effect.

26.1-02-07. Unauthorized contracts valid. The failure of an insurance company transacting insurance business in this state to obtain a certificate of authority does not impair the validity of any act or contract of the company and does not prevent the company from defending any civil action in any court of this state, but a company transacting insurance business in this state without a certificate of authority may not maintain a civil action in any court of this state to enforce any right, claim, or demand arising out of the transaction of insurance business until the company has obtained a certificate of authority.

26.1-02-08. Liability of unauthorized company. If any unauthorized insurance company fails to pay any claim or loss within the provisions of its insurance contract, any person who assisted or in any manner aided directly or indirectly in the procurement of the

insurance contract is liable to the insured for the full amount of the claim or loss in the manner provided by the contract.

26.1-02-09. Restraint of violations - Jurisdiction. Whenever the commissioner believes that any insurance company is violating or is about to violate this chapter, the commissioner may, through the attorney general of this state, cause a complaint to be filed in the district court of Burleigh County to enjoin and restrain the company from continuing or engaging in any violation or doing any act in furtherance thereof. The court may make and enter an order or judgment awarding preliminary or final injunctive relief as in its judgment is proper.

26.1-02-10. Agent for service of process - Unauthorized company. Any act of transacting insurance business as set forth in this chapter by any unauthorized insurance company is an irrevocable appointment by the company, binding upon the company, its executor or administrator, or successor in interest if a corporation, of the secretary of state or the secretary's successor in office, as the attorney of the company upon whom may be served all lawful process in any action or proceeding in any court by the commissioner or by the state and upon whom may be served any notice, order, pleading, or process in any proceeding before the commissioner and which arises out of transacting insurance business in this state by the company. Any act of transacting insurance business in this state by any unauthorized company signifies its agreement that any lawful process in any court action or proceeding and any notice, order, pleading, or process in any administrative proceeding before the commissioner so served is of the same legal force and validity as personal service of process in this state upon the company.

26.1-02-11. Service of process - How made. Service of process is made by delivering to the secretary of state, or some person in apparent charge of the secretary's office, two copies thereof and by payment to the secretary of state of the fee prescribed by law. The secretary of state immediately shall forward by registered mail one copy to the defendant in a court proceeding, or to whom the process is addressed or directed in an administrative proceeding, at its last reasonably ascertainable address. The secretary of state shall keep a record of the date and hour of service. This service is sufficient if notice of the service and a copy of the process is mailed within ten days thereafter by certified mail to the defendant by the plaintiff or the plaintiff's attorney in a court proceeding, or to whom the process is addressed or directed by the commissioner in an administrative proceeding, at its last reasonably ascertainable address, and the defendant's receipt issued by the post office with which the letter is registered, showing the name of the sender of the letter and the name and address of the person or insurer to whom the letter is addressed, and an affidavit of mailing showing compliance herewith is filed with the clerk of the court in which the proceeding is pending, or with the commissioner in an administrative proceeding. No judgment or determination by default may be entered in any proceeding until the expiration of forty-five days from the date of filing of the affidavit of compliance.

This section does not limit or affect the right to serve any process upon any person or insurer in any other manner permitted by law.

26.1-02-12. Pleading by unauthorized insurance company - When permitted. Before any unauthorized insurance company files or causes to be filed any pleading in any court proceeding instituted against the company by service made as provided in section 26.1-02-11, the company must either:

1. File with the clerk of the court in which the proceeding is pending a cash or other bond with good and sufficient sureties, to be approved by the clerk, in an amount fixed by the court sufficient to secure payment of any final judgment which may be rendered in the action; or

2. Procure a certificate of authority to transact the business of insurance in this state. In considering the application for a certificate of authority, for the purposes of this subsection, the commissioner need not assert section 26.1-11-06 against the company with respect to its application if the commissioner determines that the company would otherwise comply with the requirements for the certificate of authority.

26.1-02-13. Enforcement of decisions or orders. The attorney general upon request of the commissioner may proceed in the court of this state or any reciprocal state to enforce an order or decision in any court proceeding or in any administrative proceeding before the commissioner.

26.1-02-14. List of reciprocal states. The commissioner shall determine which states qualify as reciprocal states and shall maintain at all times an up-to-date list of reciprocal states.

26.1-02-15. Filing and status of foreign decrees. A certified copy of any foreign decree may be filed in the office of the clerk of any district court of this state and concurrently in the office of the commissioner with information showing which district court is being used. The clerk, upon receiving verification from the commissioner, shall treat the foreign decree in the same manner as a decree of the district court. A filed foreign decree has the same effect as a decree of a district court of this state, and is subject to the same procedures, defenses, and proceedings for reopening, vacating, or staying as a decree of a district court and may be enforced or satisfied in like manner.

26.1-02-16. Verification - Notice of filing. At the time a foreign decree is filed in this state, the commissioner shall make and file with the clerk of the appropriate district court an affidavit setting forth the name and last known post-office address of the defendant and verifying that the decree or order is a foreign decree. Promptly upon receipt of the affidavit, the clerk shall mail notice of the filing of the foreign decree to the defendant at

the address contained in the affidavit and to the commissioner and shall make a note of the mailing in the docket.

26.1-02-17. Enforcement of foreign decrees - Time limit. No execution or other process for enforcement of a foreign decree may issue until thirty days after the date the decree is filed.

26.1-02-18. Stay of enforcement. If the defendant shows the district court that an appeal from the foreign decree is pending or will be taken, or that a stay of execution has been granted, the court must stay enforcement of the foreign decree until the appeal is concluded, the time for appeal expires, or the stay of execution expires or is vacated, upon proof that the defendant has furnished the security for the satisfaction of the decree required by the state in which it was rendered. If the defendant shows the district court any ground upon which enforcement of a decree of any district court of this state would be stayed, the court must stay enforcement of the foreign decree for an appropriate period, upon requiring the same security for satisfaction of the decree as would be required in this state.

26.1-02-19. Fees. Any person filing a foreign decree shall pay a ten dollar filing fee to the clerk of court. Fees for docketing, transcriptions, or other enforcement proceedings are as provided for decrees of the district court.

26.1-02-20. Reinsurance permitted - Limitations. Except as otherwise provided by this section and section 26.1-02-22, any insurance company organized or admitted to transact business in this state, including a mutual company, may reinsure any part or all of any risk taken by it in any insurance company or insurer licensed in any state if that company or insurer conforms to the same standards of solvency which would be required if, at the time the reinsurance is effected, it was licensed in this state. An insurance company organized or admitted to transact business in this state may reinsure a part or all of any risk taken by it in an insurance company or insurer not licensed in any state, if it is approved or accepted by the commissioner. A county mutual insurance company also may reinsure with any other county mutual insurance company. No reinsurance, however, may be effected with any company disapproved therefor by written order of the commissioner filed in the commissioner's office. A domestic insurance company organized to engage in the business of life, accident, or health insurance may not reinsure its risks or any part thereof without complying with chapter 26.1-07.

26.1-02-21. Reinsurance - Treatment upon insolvency, liquidation, or dissolution. No credit may be allowed, as an admitted asset or as a deduction from liability, to any ceding insurer for reinsurance, unless the reinsurance is payable by the assuming insurer on the basis of the liability of the ceding insurer under the contract or contracts reinsured without diminution because of the insolvency of the ceding insurer or to its domiciliary liquidator or receiver except where (1) the contract specifically provides another payee of

such reinsurance in the event of the insolvency of the ceding insurer; and (2) the assuming insurer with the consent of the direct insured has assumed such policy obligations of the ceding insurer as direct obligations of the assuming insurer to the payees under the policies and in substitution for the obligations of the ceding insurer to the payees.

26.1-02-22. Accepting reinsurance of unauthorized company prohibited. An insurance or surety company may not assume the whole or any part of any risk covering property located in this state, as a reinsurance company or in any other manner, insured by any insurance company not authorized to transact business in this state.

26.1-02-23. Revocation of company's authority to do business in this state. The commissioner shall revoke the certificate of authority of an insurance, bonding, surety, or indemnity company immediately if, at any time after examination, the commissioner has reason to believe that:

1. Any annual statement or other report required to be submitted by an officer or agent of the company pursuant to this title is false; or

2. The company is practicing discrimination against individual risks in the issue or cancellation of policies, bonds, or other contracts of insurance or corporate suretyship.

26.1-02-24. Copy of revocation to be mailed to company - Company to discontinue business - Setting aside of revocation. If the certificate of authority of an insurance, bonding, surety, or indemnity company is revoked pursuant to section 26.1-02-23, the commissioner shall mail a copy of the revocation to the company, or to the agents thereof in this state. Thereafter, the company and its agents may not issue any new policy, bond, or surety contract nor renew any policy, bond, or surety contract previously issued. The revocation may not be set aside, nor may a new certificate of authority be issued, until satisfactory evidence has been submitted to the commissioner showing that the company is in the condition set forth in its annual statement or other report, or that the discrimination alleged has not been practiced, or that the practice of discrimination will cease immediately, as the case may be, and that this title has been complied with by the company.

26.1-02-25. Penalty. Any unauthorized insurance company or other insurance entity or any representative or agent of the company or entity that transacts any unauthorized act of insurance business as provided by this chapter is guilty of a class A misdemeanor.

SECTION 3. Chapter 26.1-03 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-03-01. Limitation on risks acceptable by company. An insurance company transacting an insurance business in this state may not

expose itself to loss on any one risk or hazard to an amount exceeding ten percent of its paid-up capital and surplus if a stock company, or ten percent of its surplus if a mutual company, unless the excess is reinsured.

26.1-03-02. Valuation of securities held by company. All bonds or other evidences of debt having a fixed term and rate held by any insurance company authorized to do business in this state, if amply secured and not in default as to principal or interest, may be valued as follows:

1. If purchased at par, at the par value thereof.

2. If purchased above or below par, on the basis of the purchase price adjusted so as to bring the value to par at maturity and so as to yield, in the meantime, the effective rate of interest at which the purchase was made.

The purchase price may not be taken at a higher figure than the actual market value at the time of purchase, and the commissioner has full discretion in determining the method of calculating these values.

26.1-03-03. Cooperative and assessment life associations - Valuation of policies. Cooperative or assessment life associations shall be admitted to transact business in this state upon compliance with the provisions of this title relating to the licensing and admission of life insurance companies without being required to value their policies in conformity with chapter 26-10.1. These associations must value their policies in the same manner as yearly renewable term policies are valued, according to the standard of valuation of life insurance policies prescribed by this title.

26.1-03-04. Assets required of cooperative and assessment life associations. Every cooperative or assessment life association authorized to do business in this state must accumulate and maintain assets in excess of actual liabilities for death losses sustained and expenses incurred equal to two percent of all insurance which the association has in force. The assets must be cash, money on deposit in banks, and securities eligible for investment by insurance companies under this title.

26.1-03-05. Surplus of life company doing business on mutual plan apportioned annually. Every life insurance company conducted on the mutual plan, or upon any other plan in which the policyholders are entitled to share in the profits or surplus of the company, doing business in this state must make an annual apportionment and accounting of divisible surplus to each policyholder beginning not later than the end of the third policy year. Each policyholder is entitled to, and must be credited with or paid in the manner provided in this chapter, the portion of the entire divisible surplus as has been contributed thereto by the policyholder's policy. Every life insurance company, upon policies other than industrial policies, issued before July 1, 1907, under the

conditions of which the distribution of surplus was deferred to a fixed or specified time and made contingent upon the policy being in force and the insured living at that time, must ascertain annually the amount of surplus to which all of the policies as a separate class are entitled, and must apportion to the policies as a class the amount of surplus so ascertained and must carry the amount of the apportioned surplus, and the actual interest earnings and accretions of the fund, as a distinct and separate liability to the class of policies on and for which the same was accumulated. Neither the company nor any of its officers may use any part of the apportioned surplus for any purpose whatsoever other than for the express purpose for which the apportioned surplus was accumulated.

26.1-03-06. Life company may maintain contingency reserve - Limitations. Any life insurance company doing business in this state may accumulate and maintain, in addition to the capital and surplus contributed by its stockholders and in addition to an amount equal to the net values of its policies computed according to the laws of the jurisdiction under which it is organized, a contingency reserve not exceeding the following respective percentages of the net values:

1. When the net values are less than one hundred thousand dollars, twenty percent thereof or the sum of ten thousand dollars, whichever is the greater.

2. When the net values are greater than one hundred thousand dollars, the percentage thereof measuring the contingency reserve decreases one-half of one percent for each one hundred thousand dollars of the net values up to one million dollars and may include one-half of one percent for each additional one million dollars up to ten million dollars.

3. If the net values equal or exceed the last mentioned amount, the contingency reserve may not exceed ten percent thereof.

As the net values of the policies increase and the maximum percentage measuring the contingency reserve decreases, the company may maintain the contingency reserve already accumulated, although for the time being, it may exceed the maximum percentage herein prescribed. The company, however, may not add to the contingency reserve when the addition will bring it beyond the maximum percentage prescribed in this section. For cause shown, the commissioner may permit a company to accumulate and maintain a contingency reserve in excess of the limit specified in this section for a prescribed period, not exceeding one year under any one permission, by filing in the commissioner's office a decision stating the reasons therefor and causing the same to be published in the commissioner's next annual report. This section does not apply to any company doing exclusively a nonparticipating business.

26.1-03-07. Annual statement to be filed. Every insurance company doing business in this state must transmit to the commissioner, not later than March first of each year, a statement of its condition and business for the year ending on the preceding December thirty-first. A company organized under the law of any foreign country or province must include in the statement only business transacted within the United States, and must file a supplemental statement of business transacted without the United States not later than December first. The commissioner shall stamp the date of receipt on every statement. The commissioner may not accept the annual statement from any company if the statement was transmitted after the date designated in this section unless the statement is accompanied by the penalty prescribed by section 26.1-03-16.

26.1-03-08. Statements of receiver of company. A receiver of an insurance company doing business in this state, on or before June thirtieth of each year, and at any other time, when required to do so by the commissioner, shall make and file a statement of the assets and liabilities of the company and of the income and expenditures during the receivership in the same manner and form as is required by this chapter from the officers of insurance companies. A receiver is subject to the same penalty for the failure or refusal to make and file the statement.

26.1-03-09. Statements to be verified by specified officers - Duty of commissioner to distribute information. The annual statement must be verified by the signature and oath of the president or the vice president and of the secretary, the actuary, if a life insurance company, and the treasurer or corresponding person having charge of the accounts and finances of the insurance company, or by a majority of the members of the board of directors of the company. The commissioner shall arrange the information in the statements in a tabular form and annually print and distribute the information to the companies doing business in this state and to the legislative assembly.

26.1-03-10. Publication of abstract of annual statement and certificate of authority. An insurance company, at the time it submits its annual statement for filing, must submit an abstract of the annual statement for publication upon the form prescribed by the commissioner. The abstract of the annual statement of each company, other than a state or county mutual insurance company, must be published at least three times in one newspaper of general circulation, designated by the commissioner, printed and published in each judicial district in this state in which the company has an agency. The abstract of the annual statement of each state or county mutual insurance company must be published once in a newspaper published in the county in which the company has its principal place of business, the newspaper to be designated by the members of the company at their annual meeting. The certificate of authority issued by the commissioner to authorize the company to do business within this state must be published in connection with the publication of the abstract of its annual statement. The fees for publication are those provided under section 46-05-03. Proof of

publication must be filed with the commissioner within four months after the filing of the annual statement.

26.1-03-11. Fire companies to report statistical data - Failure to report - Exceptions to reporting requirements. Each insurance company issuing fire insurance policies covering property in this state must annually report information setting forth the amount of earned premiums in this state for policies covering insured property located in this state and the amount of claims incurred. This information is not to include personal lines or farm property insurance. This information must be reported on a form prescribed by the commissioner. The company must file the form with the commissioner or must certify to the commissioner that the information has been reported directly to a rating organization that predicates the majority of the fire insurance rates for North Dakota. The form or certification must accompany the annual statement required under section 26.1-03-07. The commissioner shall forward information filed under this section to the rating organization that predicates a majority of the fire insurance rates for North Dakota. Each rating organization filing rates pursuant to chapter 26.1-25 must use this information in making rates. The commissioner shall revoke the certificate of authority of an insurance company failing to file the information required by this section.

26.1-03-12. Definition of product liability insurance. In sections 26.1-03-12 through 26.1-03-15, unless the context or subject matter otherwise requires, "product liability insurance" means both product liability and completed operations liability insurance and includes:

1. Any policy of insurance insuring only the insured's legal obligations arising from product liability or completed operations exposure of the insured.

2. Any other policy of insurance in which the premium computation includes a premium charge for product liability or completed operations exposure of the insured.

3. Any other insurance policy which provides product liability or completed operations insurance.

26.1-03-13. Reporting of product liability information. Every insurance company providing product liability insurance or excess insurance above self-insurance to any manufacturer, seller, or distributor in this state must file with the commissioner annually, not later than April first, a report containing the following information for the one-year period ending December thirty-first of the previous year:

1. The name of the insurance company.

2. The name of all other insurance companies associated with the company submitting the report.

3. The states in which the company has been admitted for product liability insurance.

4. The dollar amount collected in product liability earned premiums and the dollar amount of product liability incurred losses in this state and on a nationwide basis.

5. The amounts shown in answer to subsection 4 which include any other insurance delivered as part of a package which cannot be considered exclusively product liability insurance.

6. The total number of insureds, resident or located in North Dakota, for which the insurance company provided product liability insurance.

7. The total number of insureds, resident or located in North Dakota, whose product liability insurance coverage the company canceled or refused to renew and the reasons therefor.

8. The percentage of product liability premiums that are incurred for the following:

   a. Losses, including all loss adjustment expenses ratioed to premiums earned.

   b. Commissions, ratioed to premiums written.

   c. Taxes, ratioed to premiums written.

   d. All other expenses, ratioed to premiums earned.

   e. The total of all expenses included in subdivisions a through d, ratioed to premiums earned.

   f. Profits and reserves, ratioed to premiums earned.

9. The basis upon which the company allocates premiums received and losses incurred from a multistate product liability risk, whether it be assigned to the risk's state or domicile, allocated to each state in which the risk has a physical plant, allocated to each state on the basis of sales in each state, or allocated on some other basis.

The report must be in the format established by the commissioner and a copy of the insurance company's most recent annual report to shareholders or policyholders must be submitted with the report. If any of the required data is estimated, that fact must be clearly indicated.

26.1-03-14. Confidentiality of product liability information reports. The commissioner may make reports required by section 26.1-03-13 available to the public, but any reports made available to the

public must be made in a manner that will not reveal the names of any person, manufacturer, or seller involved.

26.1-03-15. Limitation of liability. No liability, and no cause of action of any nature, arises against any insurance company or its agents or employees, or the commissioner or the commissioner's employees, for any action taken by them pursuant to sections 26.1-03-13 and 26.1-03-14.

26.1-03-16. Penalty for not making statement. Any insurance company doing business in this state which neglects to make and file any statement in the manner and within the time prescribed in this chapter forfeits one hundred dollars for each day's neglect, and upon notice by the commissioner to that effect, its authority to do new business ceases during the default. Any new business done by an insurance company after it has neglected to make a required statement is in violation of law.

26.1-03-17. Commissioner to collect premium tax - Insurance companies generally - Domestic fire companies - Computation. Before issuing the annual certificate required by law, the commissioner shall collect the following annual taxes from insurance companies doing business within the state:

1. From every insurance company doing business in this state except stock and mutual companies organized under the laws of this state, a tax equal in amount to two and one-half percent of the gross amount of premiums, membership fees, and policy fees received in this state during the preceding year. This tax shall not apply to considerations for annuities. The tax is payable at the time when the annual statement of business required by law is filed.

2. From every domestic fire insurance company, whether mutual, stock, or otherwise, a tax upon its fire insurance premiums or assessments, or both, equal to one-half of one percent of the gross premiums and assessments, less return premiums on all direct business received by it, or by its agent for it, in cash or otherwise in this state. The tax is collected for the purpose of assisting in the maintenance of the fire marshal's department and is payable on or before March first of each year.

26.1-03-18. Insurance or surety company to file statement of business done before authorization and to pay tax. Before a surety company or an insurance company, other than a life insurance company, may be authorized to transact business in this state, the commissioner may require it to file with him a sworn statement and other proof that it has not written, or caused to be written, any surety bond or insurance contract on any person, firm, or corporation, or on property in this state, at any time prior to filing its application for a certificate of authority to do business in this state. If it appears that the company has written, or caused to be written, any

such surety bond or insurance contract while it was not authorized to do business in this state, it must file a statement of all such bonds and contracts written by it, and the company must pay the premium tax due thereon before a certificate of authority is issued to it.

26.1-03-19. Examination of companies - Times - Expense. At least triennially the commissioner shall inspect and examine the affairs of each domestic insurance company. The commissioner shall examine any such company whenever the commissioner deems it prudent to do so or upon the request of five or more of the stockholders, creditors, policyholders, or persons pecuniarily interested therein who make affidavit of their belief, with specifications of their reasons therefor, that such company is in an unsound condition. Whenever the commissioner deems it prudent for the protection of policyholders in this state, the commissioner in like manner shall examine any foreign insurance company applying for admission, or already admitted, to do business in this state, and the company must pay the same charge for the examination as is provided in section 26.1-01-07 for an official examination.

26.1-03-20. Examinations - By whom conducted - Compensation to be paid into state treasury. Qualified regular employees of the commissioner shall conduct all examinations of an insurance company required or permitted by law to be conducted by the commissioner, whether or not the examinations are convention examinations called in accordance with rules promulgated by the national association of insurance commissioners. Their compensation is to be paid out of the appropriation for the commissioner's office. Any sums paid to the employees or to the commissioner by the company examined, as an examination fee or otherwise, is state money, and forthwith shall be paid into the state treasury. Any sums paid to the employee or the commissioner as expense money for the examiner may be paid directly to the employee, and no employee may charge or collect from the state any expenses incurred in connection with any examination for or during which expenses or any part thereof have been paid by any other person, firm, or corporation.

26.1-03-21. Powers of commissioner or person making an examination. For the purposes of making any examination required or authorized by law, the commissioner, or the person making the examination, has free access to all books, papers, and securities of an insurance company relating to its business and to the books and papers kept by any of its agents, and may summon as witnesses and examine under oath the directors, officers, agents, and trustees of any such company and any other person in relation to the company's affairs, transactions, and condition.

26.1-03-22. State auditor to make examination when commissioner is disqualified. If the commissioner is a director, officer, agent, attorney, or stockholder of, or is interested directly in, any insurance company except as an insured, the state auditor or a person appointed by the state auditor shall examine the company. No

officer or agent of any insurance company doing business in this state may be appointed to examine the affairs of the company.

SECTION 4. Chapter 26.1-04 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-04-01. Limitation on right to engage in trade. An insurance company organized under this title may not deal or trade, directly or indirectly, in the buying or selling of any goods, wares, merchandise, or other commodities whatever, except such as may have been insured by the company and are claimed to be damaged by reason of the risk insured against.

26.1-04-02. Unfair methods of competition or unfair and deceptive acts or practices prohibited. A person may not engage in this state in any trade practice defined in this chapter as, or determined pursuant to this chapter to be, an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.

26.1-04-03. Unfair methods of competition and unfair or deceptive acts or practices defined. The following are unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

1. Misrepresentations and false advertising of policy contracts. Making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular, statement, sales presentation, omission, or comparison misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon, or making any false or misleading statements as to the dividends or share of surplus previously paid on any insurance policies, or making any misleading representation or any misrepresentation as to the financial condition of any person, or as to the legal reserve system upon which any life insurance company operates, or using any name or title of any policy or class of policies misrepresenting the true nature thereof, or making any misrepresentation tending to induce the lapse, forfeiture, exchange, conversion, or surrender of any insurance policy or for the purpose of effecting a pledge or assignment of or effecting a loan against any insurance.

2. False information and advertising generally. Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio station, or in any other way, an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of insurance or

with respect to any person in the conduct of that person's insurance business, which is untrue, deceptive, or misleading.

3. Defamation. Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature which is false, or maliciously critical of or derogatory to the financial condition of any person, and which is calculated to injure any person engaged in the business of insurance.

4. Boycott, coercion, and intimidation. Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion, or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.

5. False financial statements. Filing with any supervisory or other public official, or making, publishing, disseminating, circulating, or delivering to any person, or placing before the public, or causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false statement of financial condition of any person with intent to deceive.

   Making any false entry in any book, report, or statement of any person 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 the person 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 the person in any book, report, or statement of the person.

6. Stock operations and advisory board contracts. Issuing or delivering or permitting agents, officers, or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any common-law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to insurance.

7. Unfair discrimination.

   a. Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or

other benefits payable thereon, or in any other of the terms and conditions of such contract.

b. Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever.

8. Rebates.

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

b. Subsection 7 or subdivision a of this subsection do not prohibit the following practices: (1) 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 such bonuses or abatement of premiums are fair and equitable to policyholders and for the best interests of the company and its policyholders; (2) in the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the saving in collection expenses; and (3) readjusting the rate of premium for a group insurance policy based on the loss or expense experience thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for the policy year.

9. Unfair claim settlement practices. Committing any of the following acts, if done without just cause and if performed with a frequency indicating a general business practice:

   a. Knowingly misrepresenting to claimants pertinent facts or policy provisions relating to coverages at issue.

   b. Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under insurance policies.

   c. Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies.

   d. Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims submitted in which liability has become reasonably clear.

   e. Compelling insureds to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them when the insureds have made claims for amounts reasonably similar to the amounts ultimately recovered.

   f. Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

   g. Attempting settlement or compromise of claims on the basis of applications which were altered without notice to, or knowledge or consent of, insureds.

   h. Attempting to settle a claim for less than the amount to which a reasonable person would have believed one was entitled by reference to written or printed advertising material accompanying or made a part of an application.

   i. Attempting to delay the investigation or payment of claims by requiring an insured and the insured's physician to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information.

   j. Failing to affirm or deny coverage of claims within a reasonable time after proof of loss has been completed.

k. Refusing payment of claims solely on the basis of the insured's request to do so without making an independent evaluation of the insured's liability based upon all available information.

l. Providing coverage under a policy for confinement to a nursing home and refusing to pay a claim when a person covered by such a policy was confined to a hospital for three days or more and the person's physician ordered confinement for care other than custodial care. Custodial care means care which is primarily for the purpose of meeting personal needs without supervision by a registered nurse or a licensed practical nurse.

10. Unfair handling of communications by insurance company. Failing to adopt and implement reasonable standards for the prompt handling of written communications, primarily expressing grievances, received by the insurance company from insureds or claimants.

11. Refusing to insure risks. Refusing to insure risks solely because of race, color, creed, sex, or national origin.

12. Misrepresentation in insurance applications. Making false or fraudulent statements or representations on or relative to an application for an insurance policy, for the purpose of obtaining a fee, commission, money, or other benefit from any insurer, agent, broker, or individual.

26.1-04-04. Coercing purchaser or borrower to insure with particular company or agent prohibited.

1. No person, engaged in selling real or personal property or in the business of financing the purchase of real or personal property or of lending money on the security of real or personal property and no trustee, director, officer, agent, or other employee of the person may require, as a condition precedent, concurrent, or subsequent to the sale or financing the purchase of the property or to lending money upon the security of a mortgage thereon or for the renewal or extension of any such loan or mortgage or for the performance of any other act in connection therewith, that the person purchasing the property or for whom the purchase is to be financed or to whom the money is to be loaned or for whom the extension, renewal, or other act is to be granted, or performed, negotiate any policy of insurance or renewal thereof covering the property through a particular insurance company, agent, solicitor, or broker.

2. This section does not prevent the exercise by any person of the right to designate reasonable financial requirements as to the insurance company, the terms and

provisions of the policy, and the adequacy of the coverage with respect to insurance on property pledged or mortgaged to the person; nor does this section prohibit the right of any person from voluntarily negotiating or soliciting the placing of such insurance; nor does this section forbid the securing of insurance or renewal thereof at the request of the purchaser or borrower or because of the failure of the purchaser or borrower to furnish the necessary insurance or renewal thereof.

3. Violation of this section constitutes an unfair insurance practice. The person violating this section must be proceeded against under this chapter.

26.1-04-05. Discrimination by life companies and rebates and inducements by agents prohibited. A life insurance company doing business in this state may not make or permit any distinction or discrimination between insureds of the same class and with equal expectation of life in the amount or payment of premiums or rate charges for policies of life or endowment insurance, or in the dividends or other benefits payable thereon, or in any other of the terms or conditions of the contracts which it makes. A life insurance company, and no agent or solicitor therefor, either personally or by any other person, may not:

1. Make any contract of insurance, or agreement with reference thereto, other than such as is expressed plainly in the policy issued thereon.

2. Offer, promise, allow, give, set off, or pay any rebate of the whole or any part of the premium payable on the policy or the agent's commission thereon, or any special favor or advantage in the dividends, earnings, profits, or other benefit founded, arising, accruing, or to accrue thereon or therefrom.

3. Offer, promise, allow, or give any special advantage in the date of the policy or the age at which the same is issued.

4. Offer, promise, allow, or give any paid employment or contract for services of any kind, or any other valuable inducement or consideration whatever not specified in the policy contract of insurance.

5. Offer, promise, give, option, sell, or purchase, or offer to give, sell, or purchase, as inducement to insurance or in connection therewith, any stocks, bonds, securities, or property, or any dividends or profits accruing or to accrue thereon, or other thing of value whatsoever not specified in the policy.

This section does not prevent the taking of a bona fide obligation, with legal interest, in payment of any premium.

26.1-04-06. Insured persons and applicants for insurance prohibited from accepting rebates. An insurance broker, limited insurance representative, or agent of any insurance or surety company, reciprocal, benevolent society, or any other insurance organization or association, however constituted or entitled, may not grant, and an insured person or party or applicant for insurance, either directly or indirectly, may not receive or accept, or agree to receive or accept, any rebate of premium or of any part thereof, or all or any part of any agent's, insurance broker's, limited insurance representative's, or solicitor's commission thereon, or any favor or advantage, or any share in any benefit to accrue under any policy of insurance, or any other valuable consideration or inducement other than such as may be specified in the policy, except as provided in an applicable filing which is in effect under the provisions of the laws regulating insurance rates.

26.1-04-07. Misrepresentation of terms of policy and future dividends prohibited. An insurance or surety company, reciprocal, benevolent society, or any other insurance organization or association, however constituted or entitled, doing business in this state, and an officer, director, agent, or solicitor of the company, society, or organization, and an insurance broker or limited insurance representative, may not issue, circulate, or use, or cause or permit to be issued, circulated, or used, any written or oral statement or circular misrepresenting the terms of any policy issued or to be issued by the company, society, or organization, or the benefits or advantages, promised thereby, or make an estimate, with intent to deceive, of the future dividends or shares of surplus payable under the policy, or use any name or title of any policy or class of policies misrepresenting the true nature thereof.

26.1-04-08. Rulemaking. The commissioner may adopt reasonable rules necessary to identify specific methods of competition and acts or practices prohibited by section 26.1-04-03. The rules may not enlarge upon nor extend the provisions of section 26.1-04-03.

26.1-04-09. Authority of commissioner. The commissioner may examine and investigate the affairs of every person engaged in the business of insurance in this state to determine whether the person has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice prohibited by section 26.1-04-02.

26.1-04-10. State's attorney to prosecute for discrimination or misrepresentation. Upon evidence satisfactory to the commissioner that section 26.1-04-05, 26.1-04-06, 26.1-04-07, or 26.1-04-17 has been violated by any person, the commissioner shall certify to the state's attorney of the county in which the violation occurred all evidence of the violation in the commissioner's possession, and the state's attorney shall prosecute the case.

26.1-04-11. Immunity from prosecution. If any person asks to be excused from attending and testifying or from producing any evidence at any trial or hearing on the ground that the testimony or evidence

required may tend to incriminate that person or subject that person to a penalty or forfeiture, but is directed to give the testimony or produce the evidence, that person must comply with the direction. That person may not thereafter be prosecuted or subjected to any penalty or forfeiture for or on account of any transaction, matter, or thing concerning which that person may testify or produce evidence pursuant thereto, and no testimony given or evidence produced may be received against that person upon any criminal action, investigation, or proceeding. However, no individual so testifying is exempt from prosecution or punishment for any perjury committed while testifying and the testimony or evidence given or produced is admissible upon any criminal action, investigation, or proceeding concerning the perjury, nor is the individual exempt from the refusal, revocation, or suspension of any license, permission, or authority conferred, or to be conferred, pursuant to the insurance laws of this state. The individual may execute, acknowledge, and file in the office of the commissioner a statement expressly waiving such immunity or privilege in respect to any transaction, matter, or thing specified in the statement and thereupon the testimony of the individual or such evidence in relation to the transaction, matter, or thing may be received or produced before any judge or justice, court, tribunal, grand jury, or otherwise, and if received or produced the individual is not entitled to any immunity or privilege on account of any testimony given or evidence produced.

26.1-04-12. Hearing. Whenever the commissioner has reason to believe that any person has been engaged or is engaging in this state in any unfair method of competition or any unfair or deceptive act or practice defined in section 26.1-04-03, and that a proceeding would be to the interest of the public, the commissioner shall conduct a hearing.

26.1-04-13. Orders and modifications.

1. If, after 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 shall order the person to cease and desist from engaging in the method of competition, act, or practice. If the person charged is found to have willfully engaged in a method of competition, act, or practice in violation of section 26.1-04-03, the commissioner may order any one or more of the following:

   a. Payment of a monetary penalty of not more than one thousand dollars for each and every act or violation but not to exceed an aggregate penalty of ten thousand dollars unless the person knew or reasonably should have known that person was in violation of section 26.1-04-03, in which case the penalty shall be not more than five thousand dollars for each and every act or violation but not to exceed an aggregate penalty of fifty thousand dollars in any six-month period.

b. Suspension or revocation of the person's license if the person knew or reasonably should have known that person was in violation of section 26.1-04-03.

2. Until the expiration of the time allowed for an appeal if no appeal has been duly filed or, if an appeal has been filed, then until the transcript of the record in the proceeding has been filed in the district court, the commissioner may modify or set aside in whole or in part any order issued under this section.

3. After the expiration of the time allowed for filing an appeal if no appeal has been duly filed, the commissioner may, after notice and opportunity for hearing, reopen and alter, modify, or set aside, in whole or in part, any order issued under this section, whenever in the commissioner's opinion conditions of fact or of law have so changed as to require the action or if the public interest shall so require.

26.1-04-14. Penalty. Any person who violates a cease and desist order of the commissioner under section 26.1-04-13, after it has become final, and while it is in effect, shall, upon proof thereof to the satisfaction of the court, forfeit and pay to the state of North Dakota a sum not to exceed a monetary penalty of not more than ten thousand dollars for each and every act or violation.

26.1-04-15. Judicial review by intervenor. If the commissioner does not charge a violation of this chapter, then any intervenor in the proceedings may within ten days after the service of the report, cause a notice of appeal to be filed in the district court of Burleigh County for a review of the report. The court may issue appropriate orders and decrees in connection therewith, including, if the court finds that it is to the interest of the public, orders enjoining and restraining the continuance of any method of competition, act, or practice which it finds, notwithstanding the report of the commissioner, violates this chapter.

26.1-04-16. Penalty for violating provisions relating to misrepresentation and discrimination. Any officer, agent, solicitor, or representative of any insurance or surety company, reciprocal, benevolent society, or any other insurance organization, or association, or any other person, who violates section 26.1-04-05, 26.1-04-06, 26.1-04-07, or 26.1-04-17 is guilty of a class A misdemeanor. The commissioner may, after a hearing upon fifteen days' notice, revoke the license to transact business in this state of any insurance organization violating section 26.1-04-05 or 26.1-04-06.

26.1-04-17. Revocation or suspension of insurance broker's, limited insurance representative's, and agent's license for misrepresentation or discrimination. Upon satisfactory evidence of the violation of any provision of this chapter relating to misrepresentation or discrimination by any insurance broker, limited insurance representative, agent, or solicitor of any insurance or surety

company, reciprocal, benevolent society, or any other insurance organization or association, however constituted or entitled, the commissioner may suspend or revoke the license of the offending solicitor or agent.

26.1-04-18. Order does not relieve from other liability. An order of the commissioner under this chapter or order of a court affirming the commissioner's order does not relieve or absolve any person affected by the order from any liability under any other law of this state.

26.1-04-19. Chapter additional to existing law. The powers vested in the commissioner by this chapter, are additional to any other powers to enforce any penalties, fines, or forfeitures authorized by law with respect to the methods, acts, and practices declared to be unfair or deceptive by this chapter.

SECTION 5. Chapter 26.1-05 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-05-01. General powers and duties of domestic company. Every insurance company incorporated or formed by authority of any law of this state, except when otherwise expressly provided, may exercise the powers and is subject to the duties and liabilities provided by this title. The general law governing profit corporations applies to an incorporated domestic insurance company so far as the provisions are pertinent and not in conflict with provisions contained in this title relating to the company.

26.1-05-02. Organization of domestic stock company - Number of persons required - Authorized lines. Any number of persons not less than seven may form a corporation on the stock plan to carry on one or more of the following lines of insurance:

1. Against loss or damage by fire, lightning, cyclone, tornado, hail, or theft.
2. Against the risks of inland navigation and transportation.
3. Upon the lives of persons, including every kind of insurance pertaining thereto.
4. Against accidental injuries including the granting, purchasing, and paying of annuities and indemnities.
5. To transact fidelity insurance and corporate suretyship.
6. Upon automobiles covering in one policy or in separate policies fire, theft, property damage, liability, and collision insurance.
7. Covering any other hazard not specifically prohibited by the laws of this state as a subject of insurance.

8. Against legal expense.

A stock insurance company incorporated under this chapter may carry the lines of insurance mentioned in this section which have been expressed in its articles of incorporation.

26.1-05-03. Organization of domestic mutual life company - Number of organizers required. Any number of persons, not less than seven, may form a mutual life insurance company, and, together with others who may become associated with them or their successors, may become a body corporate for the purpose of carrying on the business of a mutual life insurance company. A mutual life insurance company organized under this chapter may carry insurance upon the lives of persons, including every kind of insurance pertaining thereto.

26.1-05-04. Capital stock and surplus requirements upon organization of domestic stock company - Exceptions. A stock insurance company may not be incorporated under this chapter unless it has an authorized capital stock of at least five hundred thousand dollars and a surplus of at least five hundred thousand dollars. A domestic stock insurance company may not issue any policy of insurance until at least fifty percent of the required capital stock, and all of the required surplus, has been paid in, the residue of capital stock to be paid in within twelve months from the time of filing the articles of incorporation. The commissioner, for good cause shown, may extend the time of payment of the residue for the further period of one year. If the minimum capital stock and surplus requirements at the time a stock insurance company incorporated under this chapter were less than the minimum requirements provided by this section, the stock insurance company must maintain authorized capital stock and surplus which satisfies the capital stock and surplus requirements in effect at that time.

26.1-05-05. Qualification of directors - Residence requirements of directors and executive officers. One-third of the directors and a majority of the executive officers of a domestic insurance company must be residents of this state, and each of the directors of the company, if it has capital stock, must be the owner in the director's own right of stock of the company of the par value of at least five hundred dollars.

26.1-05-06. Articles of incorporation - Contents - Filing - Company name. The articles of incorporation of a corporation organized under this chapter must set forth, in addition to what is required to be set forth under the general law governing profit corporations:

1. The kind of insurance proposed to be issued.

2. That the company will operate on the stock plan unless it is organized to engage in the life insurance business, in which case the articles must specify whether the company will operate on the stock or mutual plan.

3. The period for the commencement and termination of the company's fiscal year.

4. The period of its existence which may be perpetual.

5. The name of the company, which may be any name not previously in use by an existing corporation authorized to do business in this state, but the words "insurance company", or, if the business specified in the articles is that of life insurance and the business is to be conducted upon the mutual plan, the words "mutual life insurance company" must constitute a part of such name.

The articles must be filed in the office of the secretary of state and a certified copy must be filed with the commissioner. The commissioner may not issue a certificate to the company if, in the commissioner's judgment, the company's name too closely resembles the name of an existing corporation or is liable to mislead the public.

26.1-05-07. Examination of articles by attorney general and by commissioner - Certificate - Filing. The attorney general shall examine the articles of incorporation and any amendments and if they conform to this chapter and are consistent with the constitution and laws of this state, shall certify to the commissioner. The commissioner shall examine the company to ascertain whether it has complied with the requirements of law according to the nature of the business proposed to be transacted by it. If the commissioner is satisfied by the examination that the corporation has complied with the law, the commissioner shall deliver to it a certified copy of the articles of incorporation or amendments to the articles of incorporation and a certificate stating the corporation has complied with all requirements of law. The certified copy of the articles of incorporation or amendments to the articles of incorporation and of the certificate may be used for or against the company with the same effect as the originals and are conclusive evidence of the fact of organization of the company as of the date of the certificate.

26.1-05-08. Stock subscriptions. The individuals associated for the purpose of organizing a stock insurance company under this chapter, after having filed the articles of incorporation as required by section 26.1-05-06, may open books for subscriptions to the capital stock of the company and keep the books open until the full amount specified in the articles of incorporation is subscribed.

26.1-05-09. Commissioner authorized to regulate solicitation of proxies. A person may not, in contravention of any rules the commissioner may adopt as necessary or appropriate in the public interest or for the protection of investors, solicit or permit the use of the person's name to solicit any proxy, consent, or authorization in respect of any equity security of a domestic stock insurance company not listed on a national securities exchange and registered as such with the federal securities and exchange commission. This section applies to

every domestic stock insurance company having one hundred or more stockholders of record. However, this section does not apply to any insurance company if ninety-five percent or more of its stock is owned or controlled by a parent or an affiliated insurance company and the remaining shares are held by less than five hundred stockholders. A domestic stock insurance company which files with the federal securities and exchange commission forms of proxies, consents, and authorizations which comply with the requirements of the Securities and Exchange Act of 1934, as amended, is exempt from this section.

26.1-05-10. "Equity security" defined. "Equity security" as used in sections 26.1-05-11 through 26.1-05-15 means any stock or similar security; any security convertible, with or without consideration, into such a security, or carrying any warrant or right to subscribe to or purchase such a security; any such warrant or right; or any other security which the commissioner deems to be of similar nature and considers necessary or appropriate to treat as an equity security, by any rules the commissioner adopts in the public interest or for the protection of investors.

26.1-05-11. Statement of ownership required. Every person who is directly or indirectly the beneficial owner of more than ten percent of any class of any equity security of a domestic stock insurance company, or who is a director or an officer of the company, shall file in the office of the commissioner within ten days after becoming beneficial owner, director, or officer a statement, in the form the commissioner prescribes, of the amount of all equity securities of the company of which the person is the beneficial owner. Within ten days after the close of each month where there has been a change in ownership during the month, the person shall file in the office of the commissioner a statement, in the form the commissioner prescribes, indicating the person's ownership at the close of the month and any changes in the person's ownership which occurred during the month.

26.1-05-12. Gains to benefit company - Suit to recover. For the purpose of preventing the unfair use of information which may have been obtained by a beneficial owner, director, or officer by reason of the relationship to a domestic stock insurance company, any profit realized by that person from any purchase and sale, or any sale and purchase, of any equity security of the company within any period of less than six months, unless the security was acquired in good faith in connection with a debt previously contracted, inures to and is recoverable by the company, irrespective of any intention on the part of the beneficial owner, director, or officer in entering into the transaction of holding the security purchased or of not repurchasing the security sold for a period exceeding six months. Suit to recover the profit may be instituted at law or in equity in any court of competent jurisdiction by the company, or by the owner of any security of the company in the name and in behalf of the company if the company fails or refuses to bring suit within sixty days after request or fails diligently to prosecute the suit; but no suit may be brought more than two years after the date the

profit was realized. This section does not cover any transaction where the beneficial owner was not such both at the time of the purchase and sale, or the sale and purchase, of the security involved, or any transaction or transactions which the commissioner by rule exempts as not comprehended within the purpose of this section.

26.1-05-13. Conditions of sale. A beneficial owner, director, or officer, directly or indirectly, may not sell any equity security of a domestic stock insurance company if the person selling the security or the person's principal (1) does not own the security sold, or (2) if owning the security, does not deliver it against such sale within twenty days thereafter, or does not within five days after the sale deposit it in the mails or other usual channels of transportation. A person does not violate this section if the person proves that notwithstanding the exercise of good faith the person was unable to make such delivery or deposit within such time, or that to do so would cause undue inconvenience or expense.

26.1-05-14. Exceptions. Sections 26.1-05-11 through 26.1-05-13 do not apply to equity securities of a domestic stock insurance company if (1) the securities are registered, or are required to be registered, pursuant to section 12 of the Securities Exchange Act of 1934, as amended, or if (2) the company does not have any class of its equity securities held of record by one hundred or more persons on the last business day of the year preceding the year in which equity securities of the company would be subject to sections 26.1-05-11 through 26.1-05-13 except for this exception. Sections 26.1-05-11 through 26.1-05-13 do not apply to foreign or domestic arbitrage transactions unless made in contravention of any rules the commissioner adopts to carry out the purposes of sections 26.1-05-11 through 26.1-05-15. Section 26.1-05-12 does not apply to any purchase and sale or sale and purchase, and section 26.1-05-13 does not apply to any sale, of an equity security of a domestic stock insurance company not held by the dealer in an investment account, by a dealer in the ordinary course of business and incident to the establishment or maintenance by the dealer of a primary or secondary market (otherwise than on an exchange as defined in the Securities Exchange Act of 1934) for the security.

26.1-05-15. Rulemaking authority - Liability. The commissioner may adopt any rules necessary to administer sections 26.1-05-11 through 26.1-05-14. The commissioner may classify domestic stock insurance companies, securities, and other persons or matters within his jurisdiction and define and prescribe terms and conditions with respect to securities held in an investment account and transactions made in the ordinary course of business and incident to the establishment or maintenance of a primary or secondary market. Sections 26.1-05-11 through 26.1-05-13 do not impose any liability for any act done or omitted in good faith in conformity with any rule of the commissioner, notwithstanding that the rule may, after the act or omission, be amended or rescinded or determined by judicial or other authority to be invalid for any reason.

26.1-05-16. Capital stock reduced - Examination and certificate of commissioner. When the capital stock of an insurance company is impaired, the company, upon a vote of a majority of the stock represented at a meeting legally called for that purpose, may reduce its capital stock, and the number of shares thereof, to an amount not less than the minimum required by law. No part of its assets and property, however, may be distributed to its stockholders. Within ten days after the meeting, the company must submit to the commissioner a certificate setting forth the proceedings, the amount of the reduction, and the assets and liabilities of the company, signed and sworn to by its president, secretary, and a majority of its directors. The commissioner shall examine the facts in the case. If the facts conform to law and in the commissioner's judgment the proposed reduction may be made without prejudice to the public, the commissioner shall endorse his approval upon the certificate. Upon the filing of the certificate so endorsed, the company's articles of incorporation are deemed to be amended to conform to the certificate, the commissioner's certificate shall be issued to that effect, and the company may transact business upon the basis of such reduced capital as though the same were its original capital. The company, by a majority vote of its directors after the reduction, may require the return of the original certificates of stock held by each stockholder in exchange for new certificates in lieu thereof for the number of shares each stockholder is entitled to in the proportion that the reduced capital bears to the original capital.

26.1-05-17. Transfer of stock pending examination - Liability. A transfer of the stock of any domestic insurance company made during the pendency of any examination does not release the party making the transfer from the party's liability for loss which may have occurred previous to the transfer.

26.1-05-18. Investment of funds must be authorized by directors - Prohibited investment practices. An investment or loan, except a policy loan, may not be made by any domestic insurance company unless the investment or loan first has been authorized by the board of directors of the company or by an investment committee appointed by the board of directors of the company charged with the duty of supervising the making of loans or investments by the company. A domestic insurance company may not:

1. Subscribe to or participate in any underwriting of the purchase or sale of securities or property.

2. Enter into any transaction for the purchase or sale of any securities or property on account of the company jointly with any other person, firm, or corporation.

3. Enter into any agreement to withhold any of its property from sale, but the disposition of its property at all times is within the control of its board of directors.

4. Invest any of its funds in, or loan the funds upon, the shares of stock of any corporation except as otherwise provided in this chapter.

5. Invest any of its funds in, or loan the funds upon, any bonds or obligations, except government, state, or municipal securities, which are not secured by adequate collateral security to the full extent of the investment, except as otherwise provided in this chapter.

6. Invest its capital, surplus funds, or other assets in, or loan the same upon, any property owned by any officer or director of the company, or by any of the immediate members of the family of any such officer or director, nor in any manner which will permit any such officer or director to gain through the investment of funds of the company.

26.1-05-19. Authorized investment of funds of insurance companies. A domestic insurance company may invest any of its funds and accumulations in:

1. Securities or obligations made specifically eligible for such investment by law.

2. Bonds or other evidence of indebtedness issued, assumed, or guaranteed by the United States of America, the District of Columbia, or by any state, territory, or insular possession of the United States or by any county, city, township, school district, or other civil division of a state, including those payable from special revenues or earnings specifically pledged for the payment thereof, and those payable from special assessments.

3. Bonds or other evidences of indebtedness issued, assumed, or guaranteed by any instrumentality or agency of the United States of America.

4. Notes or bonds secured by mortgage or deed of trust insured by the federal housing administrator, debentures issued by the federal housing administrator, and securities issued by national mortgage associations.

5. Bonds issued by the industrial commission under chapter 4-36.

6. Bonds guaranteed by the economic development commission under chapter 6-09.2.

7. Bonds issued by the North Dakota municipal bond bank pursuant to chapter 6-09.4.

8. Bonds issued by the state board of higher education under chapter 15-55.

9. Revenue bonds issued by the state water conservation commission.

10. Interim financing notes issued by the state water conservation commission pursuant to chapter 61-02.

11. Warrants issued by a city under chapter 40-24.

12. Bonds or notes issued pursuant to chapter 40-33.2.

13. Bonds or other obligations issued pursuant to chapter 40-58.

14. Bonds issued under chapter 40-61.

15. Notes or other interest-bearing obligations of any state development corporation of which the company is a member, issued in accordance with chapter 10-30.

16. Bonds or other evidences of indebtedness issued, assumed, or guaranteed by the Dominion of Canada, or any province thereof, or by any municipality or district therein, provided that the obligations are valid and legally authorized and issued.

17. Mortgage bonds and debentures of any solvent railway company duly incorporated and authorized under the laws of this state or of any other state, territory, or insular possession of the United States, or of the Dominion of Canada or of any province thereof.

18. Mortgage bonds and debentures of any solvent industrial, public utility, or financial corporation duly incorporated and authorized under the laws of the United States of America or of any state, territory, or insular possession thereof, or of the Dominion of Canada or of any province thereof.

19. Preferred stock, of, or common or preferred stock guaranteed as to dividends by, and common stock of, any corporation organized under the laws of the United States, any state, territory, or possession of the United States, the District of Columbia, the Dominion of Canada or any province of the Dominion of Canada subject to the following restrictions and limitations:

    a. The company issuing the preferred stock or guaranteeing the dividends on the common stock must have earned an average amount per annum at least equal to five percent of the par value of its common and preferred stocks or in the case of stocks having no par value, of its issued or stated value outstanding at the date of purchase, over the period of seven fiscal years immediately preceding the date of

purchase or which over such period earned an average annual amount at least equal to two times the total of its annual interest charges, preferred dividends, and dividends guaranteed by it, determined with reference to the date of purchase.

b. The company issuing any common stock must have earned an average amount per annum at least equal to six percent of the par value of its capital stock, or in the case of stock having no par value of the issued or stated value of such stock, outstanding at the date of purchase over the period of seven fiscal years immediately preceding the date of purchase.

c. The company issuing or guaranteeing the stock has not been in arrears in the payment of dividends thereunder for a period of ninety days within the five-year period immediately preceding purchase of the stock.

d. Investments in preferred, guaranteed, and common stocks may not exceed in the aggregate ten percent of the life insurance company's admitted assets.

20. Savings accounts, under certificates of deposit or in any other form, in solvent banks and trust companies which have qualified for federal deposit insurance corporation protection, shares and savings accounts, under certificates of deposit, investment certificates, or in any other form, in solvent savings and loan associations organized under federal law or state law of any state which have qualified for federal savings and loan insurance corporation protection, and shares and deposit accounts, under certificates of deposit or in any other form, in solvent state or federally chartered credit unions which are insured by the national credit union administration. Investments in the shares and accounts are not limited to, or by, the amount of any such insurance protection.

21. Loans made upon the security of its own policies, if a life insurance company, but no loan on any policy may exceed the reserve value thereof.

22. Notes secured by mortgages on improved unencumbered real estate, including leaseholds substantially having and furnishing the rights and protection of a first real estate mortgage, within the United States of America or any province of the Dominion of Canada. No loan may be made under this subsection unless at the date of acquisition the total indebtedness secured by such lien does not exceed seventy-five percent of the value of the property upon which it is a lien. The loan may be made in an amount exceeding seventy-five percent so long as any amount over seventy-five percent of the value of the

property mortgaged is guaranteed or insured by the federal housing administration or guaranteed by the administrator of veterans affairs or is insured by private mortgage insurance through an insurance company authorized to do business in this state. Loans may be amortized on the basis of a final maturity not exceeding thirty years from the date of the loan with an actual maturity date of the loan at any time less than thirty years. A loan on a single-family dwelling where the loan is amortized on the basis of a final maturity twenty-five years or less from the date of the loan may be made in an amount not exceeding eighty percent of the value of the property mortgaged. The loan on a single-family dwelling may be made in an amount exceeding eighty percent so long as any amount over eighty percent of the value of the property mortgaged is insured by private mortgage insurance through an insurance company authorized to do business in this state. Buildings may not be included in the valuation of such property unless they are insured and the policies are made payable to the company as its interest may appear. A loan may not be made in excess of the amount of insurance carried on the buildings plus the value of the land. No insurance company may hold less than the entire loan represented by the bonds or notes described in this subsection except that a company may own part of an aggregate obligation if all other participants in the investment are insurance companies authorized to do business in North Dakota or banks whose depositors are insured by the federal deposit insurance corporation or savings and loan associations whose members are insured by the federal savings and loan insurance corporation or unless the security of the bonds or notes, as well as all collateral papers, including insurance policies, executed in connection therewith, are made to and held by a trustee which is a solvent bank or trust company having a paid-in capital of not less than two hundred fifty thousand dollars, except in case of banks or trust companies incorporated under the laws of the state of North Dakota, wherein a paid-in capital of not less than one hundred thousand dollars is required. In case of proper notification of default the trustee, upon request of at least twenty-five percent of the holders of the bonds outstanding, and proper indemnification, shall proceed to protect the rights of the bondholders under the provisions of the trust indentures.

23. First mortgage bonds on improved city real estate in any state, issued by a corporation duly incorporated under the laws of any state of the United States of America, if the loans on the real estate are made in accordance with the requirements as to first mortgage loans in subsection 22.

24. Real estate for the production of income or for improvement or development for the production of income subject to the following provisions and limitations:

    a. Real estate used primarily for farming or agriculture may not be acquired under this subsection.

    b. Investments made by any company under this subsection may not at any time exceed ten percent of the admitted assets of the company.

    c. An investment in any single parcel of real estate acquired under this subsection may not exceed two percent of the admitted assets of the company.

    d. The real estate, including the cost of improvements, must be valued at cost and the improvements must be depreciated annually at an average rate of not less than two percent of the original cost.

25. Land and buildings used as home or regional offices, subject to the following provisions and limitations:

    a. Land and buildings thereon in which it has its principal office and any other real estate including regional offices requisite for its convenient accommodation in the transaction of its business.

    b. Investments or total commitment in the land and buildings may not aggregate more than ten percent of the company's admitted assets without the consent of the commissioner.

    c. The real estate, including the cost of improvements, must be valued at cost and the improvements must be depreciated annually at an average rate of not less than two percent of the original cost.

26. Investments by loans or otherwise, in the purchase of electric or mechanical machines constituting a data processing system. The company may hold the system as an admitted asset for use in connection with the business of the company if, (a) its aggregate cost does not exceed five percent of the admitted assets of the company; and (b) the cost of the component machines constituting the system is fully amortized over a period of not to exceed ten years. If a data processing system consists of separate component machines acquired at different times, then the cost of each component must be amortized over a period not to exceed ten years commencing with the date of acquisition of each component.

27. Promissory notes amply secured by the pledge of bonds or other evidences of indebtedness in which the company is

authorized to invest its funds by the provisions of this section.

28. Loans, securities, or investments in addition to those permitted in this section, whether or not the loans, securities, or investments qualify or are permitted as legal investments under its charter, or under other provisions of this section or under other provisions of the laws of this state. The aggregate of such company's investments under this subsection may not exceed either five percent of the company's admitted assets, or the amount equal to the company's unassigned surplus, whichever is less.

This section does not prohibit a company from taking any action deemed necessary or expedient for the protection of investments made by it or from accepting in good faith, to protect its interests, securities, or property not mentioned in this section in payment or to secure debts due to it.

26.1-05-20. Limitation on purchase and conveyance of real property. A domestic insurance company may acquire, hold, and convey only the real property that has been:

1. Mortgaged to it in good faith by way of security for loans previously contracted or for moneys due to it.

2. Conveyed to it in satisfaction of debts previously contracted in the course of its dealings.

3. Purchased at sales on judgments, decrees, or mortgages obtained or made for debts previously contracted in the course of its dealings.

4. Acquired as an investment for the production of income or has been acquired to be improved or developed for an investment for the production of income as provided by law.

Any company may improve real property so acquired or remodel existing improvements and exchange the real property for other real property or securities, and real property acquired by the exchange may be improved or the improvements remodeled.

26.1-05-21. Real property acquired by domestic company - When sale required. All property acquired by a domestic insurance company in any manner specified in subsections 1, 2, and 3 of section 26.1-05-20 which is not necessary for the accommodation of the company or for the convenient transaction of its business must be sold and disposed of within two years after the company has acquired title, and as to any property so acquired which was necessary for the accommodation of the company or for the convenient transaction of its business, within two years after the property has ceased to be necessary for the accommodation of business. A company may not

hold any of such property for a period longer than is specified in this section unless it procures a certificate from the commissioner stating that the company's interests will suffer materially by the forced sale of the property. If the certificate is obtained, the time for the sale may be extended to the time the commissioner directs in the certificate. A company may select real property acquired under subsections 1, 2, and 3 of section 26.1-05-20 other than real property used primarily for farming and agriculture, and hold the property as an investment for income, not exceeding the total amount permitted by law for such purpose, and the property is not subject to the limitations of this section.

26.1-05-22. Liabilities of officers and directors of domestic company. Any officer or director of a domestic insurance company who makes or authorizes an investment or loan in violation of section 26.1-05-19 or 26.1-05-20 is liable personally to the stockholders of a stock insurance company, or to the policyholders of a mutual insurance company, for any loss occasioned thereby. If a company is under liability for losses equal to its net assets and the president or directors, knowing of the liability, make or assent to further insurance, they are liable personally for any loss under the insurance. If the directors allow to be insured on a single risk a larger sum than that permitted under section 26.1-03-01, they are liable for any loss thereon above the amount the company might insure lawfully, unless the excess is reinsured as required by that section.

26.1-05-23. Domestic life company to deposit securities with commissioner. A domestic life insurance company must physically deposit with the commissioner on the date on which the company files its annual statement, securities of a value equivalent to the net value of all policies the company has in force. The securities must be of a kind specified in section 26.1-05-19. The company, in lieu of the physical deposit, may file, and the commissioner shall accept, a detailed, verified statement setting forth with sufficient particularity a list of the items of security held by the company in an amount equivalent to the net value of all policies in force. The securities specified in the list, although retained by the company, must be kept separate and distinct from the other securities of the company and must be held as a deposit for the policyholders of the company under this section. This section does not prevent or prohibit a domestic life insurance company from depositing with the commissioner securities in an amount to exceed the cash value of its policies.

26.1-05-24. Commissioner may examine books and securities of domestic life company. The commissioner may examine the books, papers, securities, and business of any domestic life insurance company at any time, or may authorize any other suitable person to make the examination. The commissioner, or person authorized to make an examination, may examine under oath any officer or agent of the company, or any other person, relative to the business and management of the company. If upon the examination the commissioner is of the opinion that the company is insolvent or that its

condition is such as to render a further continuance of its business hazardous, the commissioner may require the company to deposit in the commissioner's office all securities specified in any list filed pursuant to section 26.1-05-23 and not deposited.

26.1-05-25. Securities may be exchanged - Withdrawal of securities. A domestic life insurance company, at any time, may change the securities on physical deposit or designated on the statement of securities held by the company in lieu of a deposit by substituting a like amount of the character required in the first instance. If the annual valuation of the policies in force shows them to be less than the amount of the security deposited, the company may withdraw the excess, but at least twenty-five thousand dollars worth of securities must remain on deposit at all times.

26.1-05-26. Dividends on securities property of company. A domestic life insurance company having bonds or other securities on deposit with the commissioner may collect the dividends or interest thereon upon delivering to its authorized agent the coupons or other evidence of interest as the same becomes due. If any company, however, fails to deposit additional securities when and as called for by the commissioner, or pending any proceedings to close up or enjoin the operations of the company, the commissioner shall collect the dividends or interest and add the same to the securities on deposit.

26.1-05-27. Certificate of compliance with security deposit law - Issuance - Renewal - Attachment to policies. The commissioner shall issue a certificate to a domestic life insurance company to the effect that the company does business under the compulsory reserve deposit law of North Dakota and maintains in the office of the commissioner a deposit of an amount in excess of the net value of all outstanding policies in stipulated and first-class securities deposited for the protection of the policyholders of the company when the company has:

1. Filed its annual statement; and

2. Deposited securities with the commissioner or filed a detailed list of securities held by the company in lieu of the deposit with the commissioner, the deposit and list to be renewed annually on or before March first.

The certificate expires on March thirty-first of the ensuing year and may be renewed annually upon the filing of a statement of renewal along with any additional physical deposit or additions to the statement of securities held by the company in lieu of a deposit and upon compliance with the other provisions of this section. A copy of the certificate may be attached to any policy of insurance issued by any domestic life insurance company after the certificate has been issued to it.

26.1-05-28. Securities vest in policyholders on default of domestic life company. The securities of a defaulting or insolvent domestic life insurance company, or of a company against which proceedings for

dissolution are pending, which are on deposit with the commissioner, vest in the state for the benefit of the policies on account of which the deposit was made, and the proceeds, by order of the court upon final hearing, must be divided among the policyholders proportionately to the last annual valuation of the policies, or, at any time, must be applied to the purchase of reinsurance for their benefit.

26.1-05-29. Nonapplicability of reserve deposit provisions to fraternal benefit societies. Sections 26.1-05-23 through 26.1-05-28 do not apply to fraternal benefit societies.

26.1-05-30. Disbursements by domestic life company to be made on voucher - Requirements. No domestic life insurance company may make any disbursement of one hundred dollars or more unless evidenced by a voucher signed by or in behalf of the person receiving the money and correctly describing the consideration for the payment. If the expenditure is for both services and disbursements, the voucher must set forth the services rendered and an itemized statement of the disbursements made. If the expenditure is in connection with any matter pending before any legislative or public body or before any department or officer of any state or government, the voucher, in addition, must describe correctly the nature of the matter and of the interest of the company therein. When a voucher cannot be obtained, the expenditure must be evidenced by an affidavit describing the character and object of the expenditure and stating the reason for not obtaining the voucher.

26.1-05-31. Salaries and expenses of officers and agents of domestic life company - Restrictions. A domestic life insurance company may not:

1. Pay any salary, compensation, or emolument to any officer, trustee, or director thereof, nor any salary, compensation, or emolument to any one person, firm, or corporation amounting in any one year to more than thirty thousand dollars, unless the payment thereof first is authorized by the board of directors of the company.

2. Grant any pension to any officer, director, or trustee thereof, or to any member of the officer's, director's, or trustee's family after death, except that it may provide a pension in pursuance of the terms of a retirement plan adopted by the board of directors and approved by the commissioner for any person who is or has been a salaried officer or employee of the corporation and who may retire by reason of age or disability.

26.1-05-32. Impairment of capital or surplus of domestic life company - Determination of deficiency - Notice not to issue policies. If a domestic stock life insurance company's minimum basic paid-in capital required by section 26.1-05-04 or the minimum basic surplus of a domestic mutual insurance company required by section 26.1-12-10 becomes impaired, the commissioner shall prohibit the company and its agents from issuing new policies until the deficiency is cured.

The commissioner shall determine the amount of the deficiency, notify the company of the deficiency and require the company to cure the deficiency, and require the company to file proof thereof with the commissioner within a period specified in the notice. The period may not be less than thirty days nor more than ninety days from the date of issuance of the notice.

26.1-05-33. Dividends to be paid by domestic fire company from surplus profits only - Compensation. A domestic fire insurance company may not declare any dividend except from the surplus profits arising from its business. In estimating the surplus profits, there must be reserved as unearned premiums a sum equal to forty percent of the amount of premiums on all unexpired risks and policies, and there also must be reserved all sums due the company on bonds, mortgages, stocks, and book accounts upon which no part of the principal or accrued interest has been paid during the year preceding the estimate of the profits and upon which suit for foreclosure or collection has been commenced, or a judgment upon which has remained unsatisfied for more than one year.

26.1-05-34. Reciprocal states - Restrictions on domestic companies - Exceptions. As used in this section, "reciprocal state" means a state the laws of which prohibit an insurance company domiciled therein from insuring the lives or persons of residents of, or property or operations located in, the state of North Dakota unless it holds a valid and subsisting certificate of authority issued by the commissioner of insurance of this state. The prohibition may be subject to the exceptions to this section.

A domestic insurance company may not enter into a contract of insurance upon the life or person of a resident of, or property or operations located in, a reciprocal state unless it is authorized pursuant to the laws of that state to transact such insurance therein. The commissioner shall annually mail notice to every domestic insurance company, specifying the reciprocal states.

The exceptions to this section are:

1. Contracts entered into where the prospective insurant is personally present in the state in which the insurance company is authorized to transact insurance when the insurant signs the application.

2. The issuance of certificates under a lawfully transacted group life or group disability policy, where the master policy was entered into a state in which the insurance company was then authorized to transact insurance.

3. The removal or continuance in force, with or without modification, of contracts otherwise lawful and which were not originally executed in violation of this section.

SECTION 6. Chapter 26.1-06 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-06-01. Definitions. As used in this chapter, unless the context or subject matter otherwise requires:

1. "Equity security" means any shares or similar securities, or voting trust certificates, or any securities convertible into such securities.

2. "Horizontal combination" means two or more corporations each of which has a majority of its equity securities owned by the same other corporation.

3. "Offeree" means the beneficial or record owner of equity securities which an offeror acquires or offers to acquire in connection with a takeover bid.

4. "Offeror" means a person who makes or in any way participates or aids in making a takeover bid, and includes persons acting jointly or in concert, or who intend to exercise jointly or in concert any voting rights attached to the equity securities for which the takeover bid is made.

5. "Takeover bid" means the acquisition of, or offer to acquire, pursuant to a tender offer or request or invitation for tenders, any equity security of a North Dakota domestic insurance company, if after acquisition thereof the offeror would, directly or indirectly, be a record or beneficial owner of more than five percent of any class of the issued and outstanding equity securities of such corporation. A takeover bid does not include:

   a. A bid made by a dealer for the dealer's own account in the ordinary course of the dealer's business of buying and selling the security.

   b. Any offer to acquire or acquisition of an equity security pursuant to the offer, for the sole account of the offeror, from not more than twenty persons, in good faith and not for the purpose of avoiding this chapter.

   c. Any tender offer or request or invitation for tenders to which the target company consents, by action of its board of directors, if the board has recommended acceptance to shareholders and the terms, including notice of any inducements to officers or directors which are not made available to all shareholders, have been furnished to shareholders.

6. "Target company" means a corporation whose equity securities are or are to be the subject of a takeover bid.

7. "Vertical combination" means a chain of ownership in which one corporation has a majority of its equity securities

owned by another corporation and which chain of corporate ownership may or may not continue through other corporations in which a majority of the equity securities of one corporation are owned by another.

26.1-06-02. Takeover bid - Restrictions.

1. No offeror may make a takeover bid unless at least twenty days prior thereto the offeror files with the commissioner and the target company copies of all information required by subsection 2 and either within ten days following the filing no hearing is ordered by the commissioner or requested by the target company, or a hearing is requested by the target company within that time but the commissioner finds that no cause for hearing exists, or a hearing is ordered within that time and upon the hearing the commissioner adjudicates that the proposed takeover bid and the materials being or to be distributed are not a violation of this title and that the offeror proposed to make fair, full, and effective disclosure to offerees of all information material to a decision to accept or reject the offer. No offeror may make a takeover bid if the offeror owns five percent or more of the issued and outstanding equity securities of any class of the target company, any of which were purchased within one year before the proposed takeover bid, and the offeror, before making any such purchase, or before July 31, 1971, whichever is later, failed to publicly announce the offeror's intention to gain control of the target company, and failed to make fair, full, and effective disclosure of the intention to the persons from whom the offeror acquired the securities.

2. The information to be filed with the commissioner and the target company pursuant to subsection 1 must include:

   a. Copies of all prospectuses, brochures, advertisements, circulars, letters, or other matter by means of which the offeror proposes to disclose to offerees all information material to a decision to accept or reject the offer.

   b. The identity and background of all persons on whose behalf the acquisition of any equity security of the target company has been or is to be effected.

   c. The names of all insurance companies doing business in North Dakota in which the offeror has ownership or debt interests, setting forth the ownership or debt interests, or management functions, setting forth the management functions.

   d. The source and amount of funds or other consideration used or to be used in acquiring any equity security,

including a statement describing any securities, other than the existing capital stock or long-term debt of the offeror, which are being offered in exchange for the equity securities of the target company.

e. If the offeror has ownership or debt interests, or management functions in other insurance companies doing business in the state of North Dakota, what plans exist for consolidation of any functions whatsoever of the target company with the offeror's other companies, including but not limited to, ratemaking, investment policies, or consolidation of sales functions.

f. A statement of any plans or proposals which the offeror, upon gaining control, may have to liquidate the target company, sell its assets, effect a merger or formal consolidation of it, or make any other major change in its business, corporate structure, management personnel, or policies of employment; or to assume any portion of the risks of the target company or to have the target company assume any portion of the risks, or to reinsure any of the risks of the offeror.

g. The number of shares of any equity security of the target company of which each offeror is beneficial or record owner or has a right to acquire, directly or indirectly, together with the name and address of each offeror.

h. Particulars as to any contracts, arrangements, or understandings to which an offeror is party with respect to any equity security of the target company, including without limitation transfers of any equity security, joint ventures, loan or option arrangements, puts and calls, guarantees of loan, guarantees against loss, guarantees of profits, division of losses or profits, or the giving or withholding of proxies, naming the parties to the contracts, arrangements, or understandings.

i. Complete information on the organization and operations of offeror, including without limitation the year of organization, form of organization, the jurisdiction in which it is organized, a description of each class of the offeror's capital stock and of its long-term debt, financial statements for the current period and for the three most recent annual accounting periods, a brief description of the location and general character of the principal assets of the offeror and its subsidiaries, a description of pending legal proceedings other than routine litigation to which the offeror or any of its

subsidiaries is a party or of which any of their property is the subject, a brief description of the business done and projected by the offeror and its subsidiaries and the general development of such business over the past five years, the names of all directors and executive officers together with biographical summaries of each for the preceding five years to date, and the approximate amount of any material interest, direct or indirect, of any of the directors or officers in any material transaction during the past three years, or in any proposed material transactions, to which the offeror or any of its subsidiaries was or is to be a party.

j. If the offeror is a member of a horizontal combination or a vertical combination, then the same information must be furnished and filed for each member corporation of the horizontal combination or vertical combination.

26.1-06-03. Takeover - Offer - Terms. No offeror may make a takeover bid not made to all resident holders of the equity security that is the subject of the takeover bid, or not made to the holders on the same terms as the takeover bid is made to nonresident holders of the equity security. If an offeror makes a tender offer or request or invitation for tenders for less than all the outstanding equity securities of a class, and if a greater number of securities is deposited pursuant thereto within ten days after copies of the offer or request or invitation for tenders are first published or sent or given to securityholders than the offeror is bound or willing to take up and pay for, the securities taken up must be taken up as nearly as may be pro rata, disregarding fractions, according to the number of securities deposited by each offeree. If the terms of a takeover bid are changed before its expiration by increasing the consideration offered to offerees, the offeror shall pay the increased consideration for all equity securities taken up, whether or not the securities are deposited or taken up before or after the change in the terms of the takeover bid. The pro rata requirement applies to securities deposited within ten days after notice of an increase in the consideration offered to securityholders is first published or sent or given to securityholders.

26.1-06-04. Deceptive practices. It is unlawful for any person to misstate any material fact or omit to state any material fact, necessary to make the statements made, in the light of the circumstances under which they are made, not misleading, or to engage in any fraudulent, deceptive, or manipulative acts or practices, in connection with any takeover bid, or any solicitation of offerees in opposition to or in favor of any takeover bid.

26.1-06-05. Hearing. Any hearing pursuant to this chapter must be held within forty days of the date a filing is made pursuant to section 26.1-06-02. Adjudications made pursuant to this chapter

must be made within sixty days after the filing. Upon filing an application with the commissioner for a hearing under this section, the target company must deposit with the commissioner the sum the commissioner requires to defray the costs of the hearing and any investigation which the commissioner makes in connection therewith. If the commissioner finds that the takeover bid is in violation of chapters 26.1-05 and 26.1-07 or that effective provision is not made for fair and full disclosure to offerees of all information material to a decision to accept or reject the offer, or that the takeover bid would comply with this section if amended in certain respects, or that the takeover bid is not in violation of chapters 26.1-04, 26.1-05, and 26.1-07 and that effective provision is made for fair and full disclosure to offerees of all information material to a decision to accept or reject the offer, the commissioner shall so adjudicate.

26.1-06-06. Offenses punishable by the commissioner - Penalty. The commissioner may, by order entered after a hearing on notice duly served on the defendant not less than thirty days before the date of the hearing, if it is proved that the defendant has knowingly made any misrepresentation of a material fact for the purpose of inducing the commissioner to take any action or to refrain from taking action, or has violated this chapter, or any order of the commissioner issued pursuant to this chapter, impose a penalty not exceeding five thousand dollars.

26.1-06-07. Separate offenses. Each takeover bid made in violation of the provisions of this chapter constitutes a separate offense. The commissioner may request the offeror to rescind the bid and to make restitution to the offeree, and if the offeror complies with the request no penalty may be imposed on the offeror on account of that illegal takeover bid.

26.1-06-08. Civil liabilities.

1. Any offeror who makes a takeover bid which does not comply with this chapter, or makes a takeover bid by means of an untrue statement of a material fact or any omission to state a material fact necessary in order to make the statement made, in the light of the circumstances under which they were made, not misleading (the offeree not knowing of such untruth or omission), and who does not sustain the burden of proof that the offeror did not know, and in the exercise of reasonable care could not have known, of the untruth or omission, is liable to any offeree whose shares are taken up pursuant to the takeover bid who may sue to recover the shares, together with all dividends received thereon, costs, and reasonable attorneys' fees, upon the tender of the consideration received from the offeror, or may sue for the substantial equivalent in damages if the offeror no longer owns the shares.

2. Every person who materially participates or aids in a takeover bid made by an offeror liable under subsection 1, or who directly or indirectly controls any offeror so liable, is also liable jointly and severally with and to the same extent as the offeror so liable, unless the person who so participates, aids, or controls, sustains the burden of proof that the person did not know, and in the exercise of reasonable care could not have known, of the existence of facts by reason of which the liability is alleged to exist. The contribution is as in cases of contract among the several persons so liable.

3. Any tender specified in this section may be made at any time before entry of judgment.

4. No suit may be maintained to enforce any liability created under this section unless brought within two years after the transaction upon which it is based; provided, that if any person liable by reason of subsections 1 and 3 makes a written offer, before suit is brought, to return the shares taken up pursuant to the takeover bid, together with all dividends received thereon, upon the tender of the consideration received from the offeror, or to pay damages if the offeror no longer owns the shares, no offeree may maintain a suit under this section who has refused or failed to accept the offer within thirty days of its receipt.

5. Any condition, stipulation, or provision binding any offeree to waive compliance with this chapter or of any rule or order pursuant to this chapter is void.

6. The rights and remedies provided by this chapter are in addition to any and all other rights and remedies that may exist at law or in equity.

26.1-06-09. Consent to service of process. Every nonresident offeror who makes a takeover bid is deemed to have appointed the commissioner as agent upon whom may be served, in any matter arising under this chapter, any process, notice, order, or demand except one issued by the commissioner. The commissioner or a designated person in the commissioner's office shall serve any process, notice, order, or demand issued by the commissioner by registered mail addressed to the offeror at the offeror's latest address on file. A foreign corporation which has a duly appointed agent for service of process need not comply with this section.

26.1-06-10. Enforcement - Enjoining violations. If at a hearing before the commissioner, the commissioner determines that the offeror has violated this chapter, or the commissioner's rules administering this chapter, the commissioner shall issue and cause to be served on the offeror an order requiring the offeror to cease and desist from the violation and may issue and cause to be served on the offeror an order preventing the offeror from making any

further tender offers, and may take any affirmative action as will effectuate the policies of this chapter.

The commissioner may petition any district court of this state for the enforcement of the order and for appropriate temporary relief or restraining order and shall file in the court the record of the proceedings. Upon the filing of the petition, the court must serve notice upon the offeror and thereupon has jurisdiction of the proceeding and of the question determined therein and may grant the temporary relief or restraining order as it deems just and proper, and to make and enter a decree enforcing, modifying, and enforcing as so modified, or for setting aside in whole or in part the order. The court must enforce the order unless it finds that the order was not in accordance with law, that it was in violation of the constitutional rights of the offeror, that the commissioner's rules or procedure did not afford the offeror a fair hearing, that the commissioner's findings of fact were not supported by the evidence, or that the order was not supported by the findings of fact.

26.1-06-11. Rulemaking. The commissioner may adopt reasonable rules:

1. Defining fraudulent, evasive, deceptive, or grossly unfair practices in connection with takeover bids and the terms used in this chapter.

2. Exempting from this chapter takeover bids not made for the purpose of, and not having the effect of, changing or influencing the control of a target company.

3. Covering such other matters as are necessary to give effect to this chapter.

26.1-06-12. Securities laws. This chapter does not limit or modify in any way any responsibility, authority, power, or jurisdiction of the commissioner of securities or of the securities laws of this state.

26.1-06-13. Offenses - Penalties - Statute of limitation. Any person who knowingly makes or causes to be made any false statement with respect to any matter subject to this chapter or commits any act declared unlawful by this chapter and any offeror who makes a takeover bid which does not comply with this section and sections 26.1-06-02, 26.1-06-03, and 26.1-06-04 is guilty of a class A misdemeanor. Prosecutions under this section must be instituted within two years from the date of the offense.

SECTION 7. Chapter 26.1-07 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-07-01. Domestic companies - Consolidation - Reinsurance. As used in this chapter, "consolidate" includes consolidation and merger and "reinsurance" refers to reinsurance by an assumption agreement. A domestic insurance company organized on the stock, mutual,

stipulated premium, or assessment plan may not consolidate with any other company, or reinsure its risks or any part thereof with any other company, or assume or reinsure the whole or any portion of the risks of any other company, except in the manner provided by this chapter. This chapter does not prevent a company, whether organized on the stock or mutual plan, from reinsuring a fractional part of any single risk.

26.1-07-02. Petition for allowance of consolidation or reinsurance. When any company described in section 26.1-07-01 proposes to consolidate with any other company, or to enter into any contract of reinsurance, it must file its petition with the commissioner setting forth the terms and conditions of the proposed consolidation or reinsurance contract and asking for approval or modification as provided by this chapter.

26.1-07-03. Profit by officer or employee prohibited. An officer of a company petitioning for the right to consolidate or to reinsure, and an officer or employee of the state, may not receive any compensation or gratuity, either directly or indirectly, for aiding, promoting, or in any manner assisting in the consolidation or reinsurance.

26.1-07-04. Notice of petition for consolidation or reinsurance. When a petition is filed, the commissioner shall issue an order requiring notice by mail to each policyholder of the petitioning company, of the pendency of the petition and of the time when and place where a hearing on the petition will be held. The commissioner shall publish the order of notice and the petition in five newspapers, one of which must be a daily newspaper published at the state capital, for at least two weeks before the hearing upon the petition.

26.1-07-05. Commissioner to hear petition - General duties. The commissioner shall hold a hearing on the petition and determine whether or not the consolidation or reinsurance will be allowed. At the time and place fixed in the notice, or at any other time and place fixed by adjournment, the commissioner shall proceed with the hearing and may make or order an examination into the affairs and condition of the petitioning company. The consolidation or reinsurance may be permitted only upon approval by the commissioner. The commissioner shall safeguard the interests of the policyholders of the company or companies proposing to consolidate or reinsure. If the commissioner is satisfied that the interests of the policyholders of such company or companies are protected and that no reasonable objection exists to the consolidation or reinsurance, the commissioner may approve and authorize the proposed consolidation or reinsurance or may modify or change the terms and conditions thereof in the manner the commissioner deems for the best interests of the policyholders, and may make any order with reference to the distribution and disposition of the surplus assets of the company thereafter remaining as is just and equitable to the policyholders.

26.1-07-06. Commissioner may compel attendance of witnesses - Policyholders and stockholders may appear. The commissioner may summon

and compel the attendance and testimony of witnesses and the production of evidence. Any policyholder or stockholder of a company petitioning for consolidation or for the right to reinsure may appear before the commissioner and be heard with reference thereto.

26.1-07-07. Expenses paid by petitioner. All actual expenses and costs incident to proceedings under this chapter must be paid by the company filing the petition. An itemized statement of the expenses and costs must be filed with the commissioner with a certified copy of the decision of the commissioner.

26.1-07-08. Insurance companies subject to dissolution provisions. Sections 26.1-07-08 through 26.1-07-20 apply to all domestic corporations, associations, and societies transacting an insurance business under authority of any law of this state which are:

1. Subject to examination by the commissioner;

2. Doing or attempting to do or representing that they are doing insurance business in this state; or

3. In the process of organization intending to do insurance business in this state or to become incorporated under any law of this state for the transaction of insurance business.

26.1-07-09. Grounds upon which commissioner may petition for dissolution of company - Representation by attorney general. The commissioner, or the attorney general representing the commissioner, may apply to the district court of Burleigh County for an order to show cause why the commissioner should not take possession of any insurance company described in the order and conduct its business, or for any other relief as the nature of the case and the interests of the public and of the policyholders, creditors, or stockholders of the company may require, whenever it:

1. Is insolvent;

2. Has refused to submit its books, papers, accounts, or affairs to the reasonable inspection of the commissioner or the commissioner's deputy or examiner;

3. Has neglected or refused to observe an order of the commissioner to make good any deficiency within the time prescribed by the commissioner when its capital has become impaired exceeding fifteen percent thereof, if it is a stock company, or if it is a mutual company, when its reserve has become impaired;

4. By contract of reinsurance or otherwise, has transferred or attempted to transfer substantially its entire property or business, or entered into any transaction the effect of which is to merge substantially its entire property or

business in the property or business of another corporation, association, society, or order without the written approval of the commissioner;

5. Is found, after an examination, to be in a condition that further transaction of business will be hazardous to its policyholders or creditors, or to the public;

6. Has willfully violated its charter or any law of this state; or

7. Has been found after examination that, in the case of a stock insurance company, its minimum basic paid-in capital required by section 26.1-05-04 is impaired, or that, in the case of a domestic mutual insurance company, its surplus required by sections 26.1-12-08 and 26.1-12-10 is impaired.

26.1-07-10. Petition for dissolution of company when officer refuses to give information. The commissioner may follow the procedure specified in section 26.1-07-09 against any company described in section 26.1-07-08 if any officer thereof has refused to be examined under oath touching the affairs of the company.

26.1-07-11. Preliminary hearing on petition - Transfer of proceedings - Bond. Upon the filing of a petition for liquidation or receivership under sections 26.1-07-08 through 26.1-07-20, the petition must be heard in the district court of Burleigh County, and all preliminary steps toward appointment of a receiver must be taken in that court. The court may require the commissioner or the person acting as a deputy in the liquidation proceedings to file a bond as in other receiverships. At any time after the appointment of a receiver, the court may transfer the proceedings to the district court of the county in which the company has its principal place of business for any further action as may be necessary in the same manner as civil cases are transferred on change of venue.

26.1-07-12. Injunction against transaction of business - Procedure - Operation of company. Upon the filing of an application under this chapter, or at any time thereafter, the court may issue an injunction restraining the company from the transaction of its business or the disposition of its property until the further order of the court. On the return of the order to show cause, and after a full hearing, the court must either deny the application or direct the commissioner to take possession of the property and to conduct the business of the company until, on the application either of the commissioner, the attorney general representing the commissioner, or the company, it appears to the court, after a full hearing, that the ground for the order directing the commissioner to take possession has been removed and the company can resume possession of its property and the conduct of its business.

26.1-07-13. Commissioner to be appointed receiver. In any insolvency proceeding against a company described in section 26.1-07-08, in any

court of this state, where the proceeding is initiated by the company or by someone other than the commissioner, the court having jurisdiction of the proceeding, upon the application of the commissioner after the initiation of the proceeding, or at any time during the pendency thereof, must appoint the commissioner as receiver of the company.

26.1-07-14. Court may order liquidation of company - Commissioner to direct liquidation - Procedure. If, after the institution of proceedings under sections 26.1-07-08 through 26.1-07-20 and after a full hearing on the order to show cause issued in connection therewith, the court orders a liquidation of the business of the company, the commissioner shall make and direct the liquidation. The commissioner may deal with the property and business of the company in the commissioner's own name as commissioner or in the name of the company, as the court may direct, and is vested by operation of law with title to all the property, contracts, and rights of action of the company as of the date of the order directing liquidation. The filing or recording of the order in the office of a register of deeds imparts the same notice that the proper filing or recording of a deed, bill of sale, or other evidence of title by the company would impart. The order of liquidation, unless otherwise directed by the court, must provide that the dissolution of the company takes effect upon the entry of the order in the office of the clerk of the district court of the county wherein the company had its principal office for the transaction of business.

26.1-07-15. Commissioner may appoint special deputies and employ counsel in receivership proceedings - Compensation - Powers. For the purposes of sections 26.1-07-08 through 26.1-07-20, the commissioner may appoint and delegate authority to one or more special deputy commissioners and may employ such counsel, clerks, and assistants as the commissioner deems necessary. The commissioner shall set the compensation of any special deputy commissioner, counsel, clerk, or assistant, and all expenses of taking possession and conducting the business of liquidating any company, subject to the approval of the court. The commissioner shall pay the compensation and expenses on certificate out of the funds or assets of the company. In any proceeding under sections 26.1-07-08 through 26.1-07-20, the commissioner, the commissioner's deputy, and any examiner or special deputy have all of the powers given to the commissioner by any law of this state authorizing the commissioner to make, or cause to be made, examinations of an insurance company, including the power to examine the officers and employees of a company under oath and to compel the production of evidence.

26.1-07-16. Offset - Limitations. In all cases of mutual debts or mutual credits between the insurer and another person in connection with any action or proceeding under this chapter, the credits and debits shall be set off and the balance only shall be allowed or paid, except as provided in this section. No offset may be allowed in favor of any such person where:

1. The obligation of the insurer to the person would not at the date of the entry of any liquidation order or otherwise, as provided in section 26.1-07-14 entitle that person to share as a claimant in the assets of the insurer;

2. The obligation of the insurer to the person was purchased by or transferred to that person with a view of its being used as an offset; or

3. The obligation of the person is to pay an assessment levied against the members of a mutual insurer, or against the subscribers of a reciprocal insurer, or is to pay a balance upon the subscription to the capital stock of a stock insurer.

26.1-07-17. Priority of distribution of assets. The priority of distribution of assets in a liquidation proceeding against an insurance company is:

1. Expenses of administration.

2. Compensation actually owing to employees other than officers of the company, for services rendered within three months prior to the commencement of the proceeding against the company, but not exceeding one thousand dollars for each employee, is to be paid prior to the payment of any other debt or claim, and in the discretion of the commissioner, may be paid as soon as practicable after the proceeding has been commenced; except, that at all times the commissioner shall reserve any funds that will, in the commissioner's opinion, be sufficient to the expenses of administration. This priority is in lieu of any other similar priority authorized by law as to the wages or compensation of employees.

3. Claims for taxes and debts due to federal or any state or local government which are secured by liens perfected prior to the commencement of delinquency proceedings.

4. Claims by policyholders, beneficiaries, and insured arising from and within the coverage of and not in excess of the applicable limits of insurance policies and insurance contracts issued by the company, and liability claims against the company which are within the coverage of and not in excess of the applicable limits of insurance policies and insurance contracts issued by the company.

5. Claims presented by the North Dakota insurance guaranty association and any similar organization in another state, which represent covered claims defined in section 26-36-05.

6. All other claims.

26.1-07-18. Powers and duties of commissioner and deputies in receivership proceedings - Assessments - Actions. The commissioner, the commissioner's deputy, or any special deputy appointed by the commissioner acting under sections 26.1-07-08 through 26.1-07-20 in any liquidation proceeding:

1. Has all of the powers of a receiver in insolvency proceedings generally.

2. May do or perform any act for the protection of the assets of the company, or for the recovery of the assets, and for the settlement or discharge of the obligations of the company, which may be necessary or which may be directed by the court.

3. Has the same authority as is given to the officers of the company by this title to make assessments upon stockholders or members of the company, and shall make ratable assessments in any case where the same are authorized to the extent which may be necessary to discharge the whole of the obligations of the company existing at any time during the receivership or during the insolvency proceedings.

4. May bring suit to recover and enforce any assessments made upon stockholders or members of a company in receivership, and by direction of the court having jurisdiction of the liquidation, may bring the suit in the district court and recover costs therein without regard to the amount involved.

5. Is accountable to the court having jurisdiction of the receivership or insolvency proceedings.

6. Within one hundred twenty days of a final determination of insolvency of a company by a court of competent jurisdiction in this state, shall make application to the court for approval of a proposal to disburse assets out of such company's marshalled assets, from time to time as the assets become available, to the North Dakota insurance guaranty association and to any similar organization in another state, hereafter referred to as the associations.

   a. The proposal must at least include provision for:

      (1) Reserving amounts for the payment of the expenses of administration and claims falling within the priorities established in subsections 1 through 3 of section 26.1-07-17.

      (2) Disbursement of the assets marshalled to date and subsequent disbursements of assets as they become available.

(3) Equitable allocation of disbursements to each of the associations entitled thereto.

(4) The securing by the receiver from each of the associations entitled to disbursements an agreement to return to the receiver any assets previously disbursed as may be required to pay claims of secured creditors and claims falling within the priorities established in section 26.1-07-17 in accordance with the priorities. No bond may be required of any such association.

b. The proposal must provide for disbursements to the associations in amounts at least equal to the payments made or to be made thereby for which the associations could assert claims against the receiver, and must further provide that if the assets available for disbursement from time to time do not equal or exceed the amount of such payments made or to be made by the associations then disbursements will be in the amount of available assets.

c. Notice of the application must be given to the associations in and to the commissioners of insurance of each of the states. Any notice is deemed given when deposited as certified mail, first-class postage prepaid, at least thirty days prior to submission of the application to the court. Action on the application may be taken by the court provided that the required notice has been given and that the receiver's proposal complies with paragraphs 1 and 4 of subdivision a.

26.1-07-19. Receiver may not increase liabilities of company - Exception. A receiver appointed under sections 26.1-07-08 through 26.1-07-20 may not increase the liabilities of a company undergoing liquidation, except for the purpose of preserving its assets.

26.1-07-20. Report of dissolutions and receivership made by commissioner. The commissioner shall publish, in the commissioner's annual report, the names of all companies of which the commissioner has taken possession, whether the companies have resumed business or have been liquidated, and any other facts that will acquaint the policyholders, creditors, stockholders, and the public with the commissioner's proceedings. To that end, the official in charge of any such company shall file annually with the commissioner a report of the affairs of the company.

26.1-07-21. Penalty. Any officer, director, or stockholder of any company, or any officer or employee of the state, who violates, or consents to the violation of, this chapter is guilty of a class A misdemeanor.

SECTION 8. Chapter 26.1-08 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-08-01. Definitions. In this chapter, unless the context or subject matter otherwise requires:

1. "Association" means the association created by section 26.1-08-03.

2. "Association plan" means a policy of insurance coverage offered by the association through the lead carrier.

3. "Association plan premium" means the charge for membership in the association plan based on the benefits provided in section 26.1-08-05 or 26.1-08-06 and determined pursuant to section 26.1-08-08.

4. "Eligible person" means an individual who is a resident of this state and meets the enrollment requirements of section 26.1-08-12.

5. "Health benefits" means benefits offered on an indemnity or prepaid basis which pay the costs of or provide medical, surgical, or hospital care or, if selected by the eligible person, chiropractic care.

6. "Insurance company" means a company operating pursuant to chapter 26-03.1 or 26.1-17, and offering or selling policies or contracts of accident and sickness insurance. Insurance company does not include a health maintenance organization.

7. "Lead carrier" means the insurance company selected by the association to administer the association plan.

8. "Plan of health coverage" means any plan or combination of plans of coverage, including combinations of individual policies or coverage under a nonprofit health service plan.

9. "Policy" means insurance or nonprofit health service plan contracts providing benefits for hospital, surgical, and medical care. Policy does not include coverage which is (a) limited to disability or income protection coverage, (b) automobile medical payment coverage, (c) supplemental to liability insurance, (d) designed solely to provide payment on a per diem basis, daily indemnity, or non-expense-incurred basis, or (e) credit accident and sickness insurance.

10. "Qualified plan" means those health benefit plans certified by the commissioner as providing the minimum benefits required by section 26.1-08-05 or 26.1-08-06 or the actuarial equivalent of those benefits.

26.1-08-02. Duties of commissioner. The commissioner shall:

1. Formulate general policies to advance the purposes of this chapter and adopt rules to carry out this chapter.

2. Supervise the creation of the association within the limits described in section 26.1-08-03.

3. Approve the association's contract with the lead carrier including the association plan coverage and premiums to be charged.

4. Conduct periodic audits to assure the general accuracy of the financial data submitted by the lead carrier and the association.

5. Undertake, directly or through contracts with other persons, studies or demonstration projects to develop awareness of the benefits of this chapter so that the residents of this state may best avail themselves of the health care benefits provided by this chapter.

26.1-08-03. Comprehensive health association.

1. There is established a comprehensive health association with participating membership consisting of those insurance companies, licensed or authorized to do business in this state, with an annual premium volume of accident and sickness insurance contracts, derived from or on behalf of residents in the previous calendar year, of at least one hundred thousand dollars, as determined by the commissioner.

2. The board of directors of the association must consist of ten individuals, one from each of the ten participating member insurance companies of the association with the highest annual premium volumes of accident and sickness insurance contracts as determined in subsection 1. Each board member is entitled to votes, in person or by proxy, based on the member's annual premium volume of accident and sickness insurance contracts as determined in subsection 1, in accordance with the following schedule:

$ 100,000	- 4,999,999	1 vote
$ 5,000,000	- 9,999,999	2 votes
$10,000,000	- 14,999,999	3 votes
$15,000,000 or more		4 votes

Members of the board may be reimbursed from the moneys of the association for expenses incurred by them due to their service as board members, but may not otherwise be compensated by the association for their services. The costs of conducting the meetings of the association and its board of directors must be borne by participating members of the association.

3. All participating members must enter into a contract of reinsurance with the association according to the terms specified in section 26.1-08-09. The contract of reinsurance must be executed for a period of one year and must be renewed annually thereafter. An insurance company which ceases to do business within the state remains liable under the contract for the reinsurance contracted for during that calendar year.

4. All participating members must maintain their membership in the association, as a condition for writing policies in this state.

5. The association must submit bylaws and operating rules to the commissioner for approval.

6. The association may:

   a. Exercise the powers granted to insurance companies under the laws of this state.

   b. Sue or be sued.

   c. Enter into contracts with insurance companies, similar associations in other states, or other persons for the performance of administrative functions.

   d. Establish administrative and accounting procedures for the operation of the association.

   e. Provide for the reinsuring of risks incurred as a result of issuing the coverages required by members of the association.

   f. Provide for the administration by the association of policies which are reinsured pursuant to subdivision e.

26.1-08-04. Minimum benefits of association plan. The association through its plan must offer policies which provide at least the benefits of a number one, two, and three qualified plan A and qualified plan B.

26.1-08-05. Minimum benefits of a qualified plan A.

1. A plan of health coverage is a number three qualified plan A if it otherwise meets the requirements established by chapter 26-03.1, and other laws of the state, whether or not the policy is issued in this state, and meets or exceeds the following minimum standards:

   a. The minimum benefits for covered individuals must, subject to this subdivision, be equal to at least eighty percent of the cost of covered services in

excess of an annual deductible which does not exceed one hundred fifty dollars per person. The coverage must include a limitation of three thousand dollars per person on the total annual out-of-pocket expenses for services covered under this subsection. Coverage may be subject to a maximum lifetime benefit of not less than two hundred fifty thousand dollars.

b. Covered expenses must be the usual and customary charges for the following services and articles when prescribed by a physician:

(1) Hospital services.

(2) Professional services for the diagnosis or treatment of injuries, illness, or conditions, other than outpatient mental or dental, which are rendered by a physician or at a physician's direction.

(3) Use of radium or other radioactive materials.

(4) Oxygen.

(5) Anesthetics.

(6) Diagnostic X-rays and laboratory tests.

(7) Services of a physical therapist.

(8) Transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition.

c. Covered expenses must include, at the option of the eligible person, the usual and customary charges for professional services rendered by a chiropractor and for services and articles prescribed by a chiropractor for which an additional premium may be charged.

d. Covered expenses for the services or articles specified in this subsection do not include:

(1) Drugs requiring a physician's prescription.

(2) Services of a nursing home.

(3) Services of a home health agency.

(4) Home and office calls.

(5) Prostheses.

(6) Rental or purchase of durable medical equipment.

(7) The first twenty dollars of diagnostic X-ray and laboratory charges in each fourteen-day period.

(8) Oral surgery.

(9) Any charge for any care or for any injury or disease either arising out of an injury in the course of employment and subject to a workers' compensation or similar law, for which benefits are payable without regard to fault under coverage statutorily required to be contained in any motor vehicle or other liability insurance policy or equivalent to self-insurance, or for which benefits are payable under another policy of accident and sickness insurance or medicare.

(10) Any charge for treatment for cosmetic purposes other than for surgery for the repair of an injury or birth defect.

(11) Any charge for travel other than transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition.

(12) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless the private room is prescribed as medically necessary by a physician.

(13) That part of a charge for services or articles rendered or prescribed by a physician, dentist, chiropractor, or other health care personnel which exceeds the prevailing charge in the locality where the service is provided.

(14) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles.

(15) Care which is primarily for custodial or domiciliary purposes which would not qualify as eligible services under medicare.

2. A plan of coverage is a number two qualified plan A if it meets the requirements established by the laws of this state and provides for payment of at least eighty percent of the covered expenses required by this section in excess of a deductible which does not exceed five hundred dollars per person. The coverage must include a limitation of three thousand dollars per person on the total annual out-of-pocket expenses for services covered under

subsection 1. Coverage may be subject to a maximum lifetime benefit of not less than two hundred fifty thousand dollars.

3. A plan of health coverage is a number one qualified plan A if it meets the requirements established by the laws of this state and provides for the payment of at least eighty percent of the covered expenses required by this section in excess of a deductible which does not exceed one thousand dollars per person. The coverage must include a limitation of three thousand dollars per person on the total annual out-of-pocket expenses for services covered under subsection 1. Coverage may be subject to a maximum lifetime benefit of not less than two hundred fifty thousand dollars.

26.1-08-06. Minimum benefits of a qualified plan B.

1. A plan of health coverage is a number three qualified plan B if it otherwise meets the requirements established by chapter 26-03.1, and the other laws of the state, whether or not the policy is issued in this state, and meets or exceeds the following minimum standards:

   a. The minimum benefits for covered individuals must, subject to this subdivision, be equal to at least eighty percent of the cost of covered services in excess of an annual deductible which does not exceed one hundred fifty dollars per person. The coverage must include a limitation of three thousand dollars per person on the total annual out-of-pocket expenses for services covered under this subsection. The coverage may be subject to a maximum lifetime benefit of not less than two hundred fifty thousand dollars.

   b. Covered expenses must be the usual and customary charges for the following services and articles when prescribed by a physician:

      (1) Hospital services.

      (2) Professional services for the diagnosis or treatment of injuries, illness, or conditions, other than outpatient mental or dental, which are rendered by a physician or at a physician's direction.

      (3) Drugs requiring a physician's prescription.

      (4) Services of a nursing home for not more than one hundred twenty days in a year if the services commence within fourteen days following confinement of at least three days in a hospital for the same condition.

(5) Service of a home health agency up to a maximum of one hundred eighty visits per year.

(6) Use of radium or other radioactive materials.

(7) Oxygen.

(8) Anesthetics.

(9) Prostheses.

(10) Rental or purchase, as appropriate, of durable medical equipment.

(11) Diagnostic X-rays and laboratory tests.

(12) Oral surgery for partially or completely unerupted impacted teeth, a tooth root without the extraction of the entire tooth, or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.

(13) Services of a physical therapist.

(14) Transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition.

c. Covered expenses must include, at the option of the eligible person, the usual and customary charges for professional services rendered by a chiropractor and for services and articles prescribed by a chiropractor for which an additional premium may be charged.

d. Covered expenses for the services or articles specified in this subsection do not include:

(1) Any charge for any care or for any injury or disease either arising out of an injury in the course of employment and subject to a workers' compensation or similar law, for which benefits are payable without regard to fault under coverage statutorily required to be contained in any motor vehicle or other liability insurance policy or equivalent self-insurance, or for which benefits are payable under another policy of accident and sickness insurance or medicare.

(2) Any charge for treatment for cosmetic purposes other than surgery for the repair of an injury or birth defect.

(3) Any charge for travel other than transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition.

(4) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless the private room is prescribed as medically necessary by a physician.

(5) That part of any charge for services or articles rendered or prescribed by a physician, dentist, chiropractor, or other health care personnel which exceeds the prevailing charge in the locality where the service is provided.

(6) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles.

(7) Care which is primarily for custodial or domiciliary purposes which would not qualify as eligible services under medicare.

2. A plan of health coverage is a number two qualified plan B if it meets the requirements established by the laws of this state and provides for payment of at least eighty percent of the covered expenses required by this section in excess of a deductible which does not exceed five hundred dollars per person. The coverage must include a limitation of three thousand dollars per person on the total annual out-of-pocket expenses for services covered under subsection 1. Coverage may be subject to a maximum lifetime benefit of not less than two hundred fifty thousand dollars.

3. A plan of health coverage is a number one qualified plan B if it meets the requirements established by the laws of this state and provides for the payment of at least eighty percent of the covered expenses required by this section in excess of a deductible which does not exceed one thousand dollars per person. The coverage must include a limitation of three thousand dollars per person on the total annual out-of-pocket expenses for services covered under subsection 1. Coverage may be subject to a maximum lifetime benefit of not less than two hundred fifty thousand dollars.

26.1-08-07. Certification of qualified plans. Upon application by the association or the lead carrier for certification of a plan of health coverage as a qualified plan for the purposes of this chapter, the commissioner shall make a determination within ninety

days as to whether the plan is qualified. All plans of health coverage shall be labeled as "qualified plan A", "qualified plan B", or "nonqualified" on the front of the policy or evidence of insurance. All qualified plans shall indicate whether they are number one, two, or three coverage plans.

26.1-08-08. Association plan premium. The schedule of premiums to be charged eligible persons for membership in the association plan must be designed to be self-supporting and based on generally accepted actuarial principles.

26.1-08-09. Operation of association plan.

1. Upon certification as an eligible person in the manner provided by section 26.1-08-12, an eligible person may enroll in the association plan by payment of the association plan premium to the lead carrier.

2. Not less than eighty-seven and one-half percent of the association plan premium paid to the lead carrier may be used to pay claims and not more than twelve and one-half percent may be used for payment of the lead carrier's direct and indirect expenses as specified in section 26.1-08-10.

3. Any income in excess of the costs incurred by the association in providing reinsurance or administrative services must be held at interest and used by the association to offset past and future losses due to claims expenses of the association plan or be allocated to reduce association plan premiums.

4. Each participating member of the association must share the losses due to claims expenses of the association plan pursuant to the terms of individual reinsurance contracts executed by the association with each participating member in accordance with section 26.1-08-03. Any deviation in the total claims expense of the association plan from the premium payments allocated to the payment of benefits is the liability of association members. Association members must share in the excess costs of the association plan in an amount equal to the ratio of a member's total annual premium volume for accident and sickness insurance charges, received from or on behalf of state residents, to the total accident and sickness insurance premium contract charges received by all association members from or on behalf of state residents, as determined by the commissioner. The reinsurance contracts must provide for a retroactive determination of each member's liability and payment is due within thirty days after each renewal date of the reinsurance contract. Failure by a member to tender to the association the assessed reinsurance payments within thirty days of notification by the association is grounds for termination of membership.

26.1-08-10. Administration of association plan.

1. Any participating member of the association may submit to the commissioner the policies which are being proposed to serve as the association plan. The commissioner shall prescribe by rule the time and manner of the submission.

2. Upon the commissioner's approval of the policy forms and contracts submitted, the association must select policies and contracts by a member or members of the association to be the association plan. The association must select one lead carrier to issue the qualified plans. The board of directors of the association shall prepare appropriate specifications and bid forms and may solicit bids from the members of the association for the purpose of selecting the lead carrier. The selection of the lead carrier must be based upon criteria established by the board.

3. The lead carrier shall perform all administrative and claims payment functions required by this section upon the commissioner's approval of the policy forms and contracts submitted. The lead carrier shall provide these services for a period of at least three years, unless a request to terminate is approved by the association and the commissioner. The association and the commissioner shall approve or deny a request to terminate within ninety days of its receipt. A failure to make a final decision on a request to terminate within the specified period is deemed an approval. The association shall invite submissions of policy forms from members of the association, including the lead carrier, six months prior to the expiration of each three-year period. The association shall follow subsection 2 in selecting a lead carrier for the subsequent three-year period, or if a request to terminate is approved on or before the end of the three-year period.

4. The lead carrier shall provide all eligible persons involved in the association plan an individual certificate setting forth a statement as to the insurance protection to which the person is entitled, the method and place of filing claims, and to whom benefits are payable. The certificate must indicate that coverage was obtained through the association.

5. The lead carrier shall submit to the association and the commissioner on a semiannual basis a report of the operation of the association plan. The association must determine the specific information to be contained in the report prior to the effective date of the association plan.

6. The lead carrier shall pay all claims pursuant to this chapter and shall indicate that the claim was paid by the association plan. Each claim payment must include

information specifying the procedure involved in the event a dispute over the amount of payment arises.

7. The lead carrier must be reimbursed from the association plan premiums received for its direct and indirect expenses. Direct and indirect expenses include a prorated reimbursement for the portion of the lead carrier's administrative, printing, claims administration, management, and building overhead expenses which are assignable to the maintenance and administration of the association plan. The association must approve cost accounting methods to substantiate the lead carrier's cost reports consistent with generally accepted accounting principles. Direct and indirect expenses may not include costs directly related to the original submission of policy forms prior to selection as the lead carrier.

8. The lead carrier is, when carrying out its duties under this chapter, an agent of the association and the commissioner, and is civilly liable for its actions, subject to the laws of this state.

26.1-08-11. Solicitation of eligible persons.

1. The association, pursuant to a plan approved by the commissioner, must disseminate appropriate information to the residents of this state regarding the existence of the association plan and the means of enrollment. Means of communication may include use of the press, radio, and television, as well as publication in appropriate state offices and publications.

2. The association must devise and implement means of maintaining public awareness of this chapter and must administer this chapter in a manner which facilitates public participation in the association plan.

3. All licensed accident and sickness insurance agents may engage in the selling or marketing of qualified association plans. The lead carrier shall pay an agent's referral fee of twenty-five dollars to each licensed accident and sickness insurance agent who refers an applicant to the association plan, if the applicant is accepted. The referral fees must be paid to the lead carrier from moneys received as premiums for the association plan.

4. Every insurance company which rejects or applies underwriting restrictions to an applicant for accident and sickness insurance must notify the applicant of the existence of the association plan, requirements for being accepted in it, and the procedure for applying to it.

26.1-08-12. Enrollment by eligible person.

1. The association plan must be open for enrollment by eligible persons. A person is eligible and may enroll in the plan by submission of a certificate of eligibility to the lead carrier. The certificate must provide:

   a. The name, address, and age of the applicant, and length of applicant's residence in this state.

   b. The name, address, and age of spouse and children, if any, if they are to be insured.

   c. Written evidence that the applicant has been rejected for accident and sickness insurance, or that restrictive riders or a preexisting conditions limitation, the effect of which is to reduce substantially coverage from that received by a person considered a standard risk, was required, by at least two insurance companies within six months of the date of the certificate.

   d. A designation of coverage desired.

2. Within thirty days of receipt of the certificate of application, the lead carrier shall either reject the application for failing to comply with the requirements of subsection 1 or forward the eligible person a notice of acceptance and billing information. Insurance is effective immediately upon receipt of the first month's association plan premium, and is retroactive to the date of application, if the applicant otherwise complies with this chapter.

3. An eligible person may not purchase more than one policy from the association plan.

4. A person who obtains coverage pursuant to this section may not be covered for any preexisting condition during the first six months of coverage under the association plan if the person was diagnosed or treated for that condition during the ninety days immediately preceding the filing of an application. This subsection does not apply to a person who has had continuous coverage under a family or group policy during the year immediately preceding the filing of an application.

SECTION 9. Chapter 26.1-09 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-09-01. Reciprocal or interinsurance exchange authorized. Individuals, partnerships, and corporations of this state, in this chapter referred to as subscribers, may exchange reciprocal or interinsurance contracts other than life insurance, with each other or with individuals, partnerships, and corporations of other states

and countries to provide indemnity among themselves against any loss which may be insured against under authority of law.

26.1-09-02. Domestic corporations have right to exchange contracts. Any domestic corporation, in addition to the rights, powers, and franchises specified in its articles of incorporation, as a subscriber, may exchange insurance contracts of the kind and character mentioned in this chapter. The right to exchange the contracts is incidental to the purposes for which the corporation was organized and is granted as fully as the rights and powers expressly conferred upon the corporation.

26.1-09-03. Reciprocal or interinsurance contracts - Execution. Reciprocal or interinsurance contracts may be executed by an attorney, agent, or other representative, in this chapter designated as an attorney, duly authorized and acting for the subscribers. The attorney may be a corporation. The office of the attorney may be maintained at the place designated by the subscribers in the power of attorney.

26.1-09-04. Subscribers to file verified declaration with commissioner - Contents. The subscribers contracting among themselves to conduct a reciprocal or interinsurance exchange through their attorney, shall file with the commissioner a declaration verified by the oath of the attorney, or where the attorney is a corporation, by the oath of a chief officer thereof, setting forth:

1. The name of the attorney and the name or designation under which contracts are issued. The name or designation may not be so similar to any name or designation adopted by any attorney or any insurance organization in the United States which was writing the same class of insurance prior to the adoption of the name or designation as to confuse or deceive.

2. The kind or kinds of insurance to be effected or exchanged.

3. A copy of the form of policy, contract, or agreement under or by which such insurance is to be effected or exchanged.

4. A copy of the form of the power of attorney or other authority of the attorney under which the insurance is to be effected or exchanged.

5. The location of the office from which the contracts or agreements are to be issued.

6. That applications have been made for indemnity upon at least one hundred separate risks aggregating not less than one million five hundred thousand dollars as represented by executed contracts or bona fide applications to become concurrently effective.

7. That assets conforming to section 26.1-09-08 are in the possession of the attorney and are available for payment of losses.

26.1-09-05. Attorney to file statement authorizing suit and consenting to service. Concurrently with the filing of the declaration provided for by section 26.1-09-04, the attorney shall file with the commissioner a written statement executed by the attorney for the subscribers conditioned that upon the issuance of the certificate of authority:

1. Civil actions may be brought in connection with the policies, contracts, or agreements entered into under this chapter in the county in which any property insured in the policies, contracts, or agreements is located or in which any accident insured against occurs.

2. Service of process may be made upon the commissioner in all civil actions arising in this state out of the policies, contracts, or agreements entered into under this chapter.

26.1-09-06. Consent to service of process - Judgment - Satisfaction. Service of process made upon the commissioner is valid and binding upon all subscribers at any time exchanging reciprocal or interinsurance contracts through the attorney filing the statement required under section 26.1-09-05. A judgment rendered in any case of the nature described in section 26.1-09-05 is valid and binding upon all subscribers as their liability may appear and may be satisfied out of any funds in the possession of the attorney belonging to the subscribers.

26.1-09-07. Maximum indemnity on fire risk - Statement of maximum liability on single risk. A subscriber to a reciprocal or interinsurance contract may not assume on any single fire insurance risk an amount greater than ten percent of the net worth of the subscriber. Whenever required so to do by the commissioner, the attorney shall furnish to the commissioner a statement under oath of the attorney showing the maximum amount of indemnity carried upon any single fire insurance risk.

26.1-09-08. Required assets - Reserve fund. As used in this section, "net premiums or deposits" means the advance payments by subscribers after deducting the amounts specifically provided for expenses in subscribers' agreements. Assets in cash or in securities authorized for investment of funds of insurance companies doing the same kind of business by the laws of the state in which the principal office of the exchange is located must be maintained at all times in an amount equal to fifty percent of the net annual advance premiums or deposits collected and credited to the accounts of subscribers on policies having one year or less to run and pro rata on those for longer periods, or in lieu thereof, one hundred percent of the net unearned premiums or deposits collected and credited to the accounts of subscribers. In addition to those

assets, there must be maintained a reserve in the case of all classes of liability or similar kinds of insurance, in cash or in approved or authorized securities, sufficient to discharge all liabilities on all outstanding losses arising under policies issued, calculated on the basis of net premiums or deposits, and in accordance with the laws relating to reserves for companies insuring similar risks. Whenever the assets are less than the amount required by this section or less than one hundred thousand dollars, whichever is the greater, the subscribers, or their attorney for them, shall make up the deficiency.

26.1-09-09. Annual report - Publication of annual statement - Examination. The attorney, within the time limited for filing the annual report by insurance companies transacting the same kind of business, shall make a report to the commissioner for each calendar year showing the financial condition at the office where the contracts are issued, and shall furnish any additional information and reports the commissioner requires to show the total premiums or deposits collected, the total losses paid, the total amounts returned to subscribers, and the amounts retained for expenses. The attorney may not be required to furnish the names and addresses of any subscribers. The attorney shall publish an abstract of annual statement as required by section 26.1-03-07. The business affairs and assets of the attorney are subject to visitation and examination by the commissioner at the expense of the office examined. Where the principal office of the attorney is located in another state, the commissioner, in lieu of an examination conducted by the commissioner's office as provided for in this section, may accept a certified copy of the report of examination made by the insurance office of the state where the principal office is located or by the insurance department of any other state.

26.1-09-10. Attorney's license fee and gross premium tax in lieu of other taxes. The attorney, in lieu of all other state, county, or municipal fees and taxes of any and every character in this state, shall pay annually to the state, on account of the transaction of the reciprocal or interinsurance exchange business in this state, a license fee of fifteen dollars and a tax of two and one-half percent of the gross premiums or deposits collected from subscribers in this state after deducting therefrom all sums returned to the subscribers or credited to their accounts other than for losses.

26.1-09-11. Appointment of agents by attorney - Agent's license fee. The attorney may appoint agents to represent the attorney in this state, but the agents, before writing or soliciting any of the insurance provided for under this chapter, must receive a certificate of authority from the commissioner. The fee for the certificate is that specified in section 26.1-01-07.

26.1-09-12. Certificate of authority - Issuance - Renewal - Suspension and revocation. Upon compliance with this chapter and the payment of the required fees and taxes, the commissioner shall issue a certificate of authority to the attorney in the name and title mentioned in section 26.1-09-04, to expire on the succeeding April

thirtieth. The commissioner may suspend or revoke any certificate in case of a breach of any of the conditions imposed by the chapter after a reasonable notice in writing has been given to the attorney to appear and show cause why the action should not be taken. Any attorney who procures a certificate under this chapter may have the certificate renewed annually thereafter at the time provided for the issuance of renewal certificates to insurance companies. A certificate continues in force and effect until a new certificate is issued or is specifically refused.

26.1-09-13. Solicitation without certificate of authority - Limitation. For the purpose of organization, and upon the issuance of a permit by the commissioner, powers of attorney may be solicited without a license or certificate of authority, but an attorney, agent, or other person may not effect any contract of insurance under this chapter until compliance with this chapter.

26.1-09-14. General insurance laws not applicable. Except as otherwise provided in this chapter, no insurance law of this state applies to the exchange of indemnity contracts under this chapter unless the law specifically applies to the contracts.

26.1-09-15. Penalty. Any attorney who exchanges any contract of indemnity of the kind and character specified in this chapter, and any attorney or representative of the attorney who solicits or negotiates any application for such contract without complying with this chapter, is guilty of a class B misdemeanor.

SECTION 10. Chapter 26.1-10 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-10-01. Definitions. As used in this chapter, unless the context or subject matter otherwise requires:

1. "Affiliate" means a person that directly, or indirectly through one or more intermediaries, controls, or is under the control of, or is under common control with, the person specified.

2. "Control" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control is presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing ten percent or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided for in subsection 9 of section 26.1-10-04, that control does not exist in fact. The commissioner may determine, after furnishing all persons in interest notice and

opportunity to be heard and making specific findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

3. "Insurance company" means an insurer as described in section 26-02-02, except that it does not include:

   a. Agencies, authorities, or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

   b. Fraternal benefit societies.

   c. Nonprofit medical and hospital service associations.

4. "Insurance holding company system" means two or more affiliated persons, one or more of which is an insurance company.

5. "Person" does not include any securities broker performing no more than the usual and customary broker's function.

6. "Securityholder" of a specified person means the owner of any security of the person, including common stock, preferred stock, debt obligations, and any other security convertible into or evidencing the right to acquire any of the foregoing.

7. "Subsidiary" of a specified person means an affiliate under the control of the person directly, or indirectly through one or more intermediaries.

8. "Voting security" includes any security convertible into or evidencing a right to acquire a voting security.

26.1-10-02. Subsidiaries - Additional investment authority - Exception from investment restrictions.

1. Any domestic insurance company, either by itself or in cooperation with one or more persons, may organize or acquire one or more subsidiaries engaged in the following kinds of business:

   a. Any kind of insurance business authorized by the jurisdiction in which it is incorporated.

   b. Acting as an insurance broker or as insurance agent for its parent or for any of its parent's insurance company subsidiaries.

c. Investing, reinvesting, or trading in securities for its own account, that of its parent, any subsidiary of its parent, or any affiliate or subsidiary.

d. Management of any investment company subject to or registered pursuant to the Investment Company Act of 1940, as amended, including related sales and services.

e. Acting as a broker-dealer subject to or registered pursuant to the Securities Exchange Act of 1934, as amended.

f. Rendering investment advice to governments, government agencies, corporations, or other organizations or groups.

g. Rendering other services related to the operations of an insurance business including, but not limited to, actuarial, loss prevention, safety engineering, data processing, accounting, claims, appraisal, and collection services.

h. Ownership and management of assets which the parent corporation could itself own or manage.

i. Acting as administrative agent for a governmental instrumentality performing an insurance function.

j. Financing of insurance premiums, agents, and other forms of consumer financing.

k. Any other business activity determined by the commissioner to be reasonably ancillary to an insurance business.

l. Owning a corporation or corporations engaged or organized to engage exclusively in one or more of the businesses specified in this section.

2. In addition to investments in common stock, preferred stock, debt obligations, and other securities permitted under all other sections, a domestic insurance company may also:

a. Invest, in common stock, preferred stock, debt obligations, and other securities of one or more subsidiaries, amounts which do not exceed the lesser of five percent of the insurance company's admitted assets or fifty percent of the company's surplus as regards policyholders; provided, that after the investments the company's surplus as regards policyholders will be reasonable in relation to the company's outstanding liabilities and adequate to its

financial needs. In calculating the amount of the investments, there must be included:

(1) Total net moneys or other consideration expended and obligations assumed in the acquisition or formation of a subsidiary, including all organizational expenses and contributions to capital and surplus of such subsidiary whether or not represented by the purchase of capital stock or issuance of other securities.

(2) All amounts expended in acquiring additional common stock, preferred stock, debt obligations and other securities, and all contributions to the capital or surplus, of a subsidiary subsequent to its acquisition or formation.

b. If the insurance company's total liabilities, as calculated for national association of insurance commissioners annual statement purposes, are less than ten percent of assets, invest any amount in common stock, preferred stock, debt obligations, and other securities of one or more subsidiaries; provided, that after the investment the company's surplus as regards policyholders, considering the investment as if it were a disallowed asset, will be reasonable in relation to the company's outstanding liabilities and adequate to its financial needs.

c. Invest any amount in common stock, preferred stock, debt obligations, and other securities of one or more subsidiaries; provided, that each subsidiary agrees to limit its investments in any asset so that the investments will not cause the amount of the total investment of the insurance company to exceed any of the investment limitations specified in subsection 1. "The total investment of the insurance company" includes:

(1) Any direct investment by the company in an asset.

(2) The company's proportionate share of any investment in an asset by any subsidiary of the company, which must be calculated by multiplying the amount of the subsidiary's investment by the percentage of the company's ownership of such subsidiary.

d. With the approval of the commissioner, invest any amount in common stock, preferred stock, debt obligations, or other securities of one or more subsidiaries; provided, that after such investment the insurance company's surplus as regards policyholders will be reasonable in relation to the company's

outstanding liabilities and adequate to its financial needs.

e. Invest any amount in the common stock, preferred stock, debt obligations, or other securities of any subsidiary exclusively engaged in holding title to and managing or developing real or personal property, if after considering as a disallowed asset so much of the investment as is represented by subsidiary assets which if held directly by the insurance company would be considered as a disallowed asset, the company's surplus as regards policyholders will be reasonable in relation to the company's outstanding liabilities and adequate to its financial needs, and if following the investment all voting securities of the subsidiary would be owned by the company.

3. Investments in common stock, preferred stock, debt obligations, or other securities of subsidiaries made pursuant to subsection 2 are not subject to any of the otherwise applicable restrictions or prohibitions applicable to such investments of insurance companies.

4. Whether any investment pursuant to subsection 2 meets the applicable requirements thereof is to be determined immediately after such investment is made, taking into account the then outstanding principal balance on all previous investments in debt obligations, and the value of all previous investments in equity securities as of the date they were made.

5. If an insurance company ceases to control a subsidiary, it must dispose of any investment therein made pursuant to this section within three years from the time of the cessation of control or within such further time as the commissioner prescribes, unless at any time after the investment has been made, the investment has met the requirements for investment under any other section, and the company has so notified the commissioner.

26.1-10-03. Acquisition of control of or merger with domestic company - Filing requirements - Hearings - Exceptions - Violations - Jurisdiction - Consent to service of process.

1. A person other than the issuer may not make a tender offer for or a request or invitation for tenders of, or enter into any agreement to exchange securities for, seek to acquire, or acquire, in the open market or otherwise, any voting security of a domestic insurance company if, after consummation, the person would, directly or indirectly, or by conversion or by exercise of any right to acquire, be in control of the company, and a person may not enter into an agreement to merge with or otherwise to acquire control of a domestic insurance company unless, at the time the

offer, request, or invitation is made or the agreement is entered into, or prior to the acquisition of the securities if no offer or agreement is involved, the person has filed with the commissioner and has sent to the company, and the company has sent to its shareholders, a statement containing the information required by this section and the offer, request, invitation, agreement, or acquisition has been approved by the commissioner in the manner hereinafter prescribed. For purposes of this section, a domestic insurance company includes any other person in control of a domestic insurance company unless the other person is either directly or through its affiliates primarily engaged in business other than the business of insurance.

2. The statement to be filed with the commissioner must be made under oath or affirmation and must contain the following information:

a. The name and address of each person by whom or on whose behalf the merger or other acquisition of control referred to in subsection 1 is to be effected, hereinafter called the "acquiring party":

(1) If the person is an individual, the individual's principal occupation and all offices and positions held during the past five years, and any conviction of crimes other than minor traffic violations during the past ten years.

(2) If the person is not an individual, a report of the nature of its business operations during the past five years or for any lesser period as the person and any predecessors thereof have been in existence; an informative description of the business intended to be done by the person and the person's subsidiaries, and a list of all individuals who are or who have been selected to become directors or executive officers of the person, or who perform or will perform functions appropriate to these positions. The list must include for each individual the information required by this subsection.

b. The source, nature, and amount of the consideration used or to be used in effecting the merger or other acquisition of control, a description of any transaction wherein funds were or are to be obtained for any such purpose, and the identity of persons furnishing the consideration; provided, however, that where a source of the consideration is a loan made in the lender's ordinary course of business, the identity of the lender must remain confidential, if the person filing the statement so requests.

c. Fully audited financial information as to the earnings and financial condition of each acquiring party for the preceding five fiscal years of each acquiring party, or for any lesser period as the acquiring party and any predecessors thereof have been in existence, and similar unaudited information as of a date not earlier than ninety days prior to the filing of the statement.

d. Any plans or proposals which each acquiring party may have to liquidate the insurance company, to sell its assets or merge or consolidate it with any person, or to make any other material change in its business or corporate structure or management.

e. The number of shares of any security referred to in subsection 1 which each acquiring party proposes to acquire, and the terms of the offer, request, invitation, agreement, or acquisition referred to in subsection 1, and a statement as to the method used to arrive at the fairness of the proposal.

f. The amount of each class of any security referred to in subsection 1 which is beneficially owned or concerning which there is a right to acquire beneficial ownership by each acquiring party.

g. A full description of any contracts, arrangements, or understandings with respect to any security referred to in subsection 1 in which any acquiring party is involved, including but not limited to transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. The description must identify the persons who have entered into the contracts, arrangements, or understandings.

h. A description of the purchase of any security referred to in subsection 1 during the twelve calendar months preceding the filing of the statement, by any acquiring party, including the dates of purchase, names of the purchasers, and consideration paid or agreed to be paid therefor.

i. A description of any recommendations to purchase any security referred to in subsection 1 made during the twelve calendar months preceding the filing of the statement, by any acquiring party, or by anyone based upon interviews or at the suggestion of the acquiring party.

j. Copies of all tender offers for, requests or invitations for tenders of, exchange offers for, and agreements to acquire or exchange any securities referred to in subsection 1, and, if distributed, of additional soliciting material relating thereto.

k. The term of any agreement, contract, or understanding made with any broker-dealer as to solicitation of securities referred to in subsection 1 for tender, and the amount of any fees, commissions, or other compensation to be paid to broker-dealers with regard thereto.

l. Any additional information the commissioner by rule prescribes as necessary or appropriate for the protection of policyholders and securityholders of the insurance company or in the public interest.

If the person required to file the statement referred to in subsection 1 is a partnership, limited partnership, syndicate, or other group, the commissioner may require that the information called for by subdivisions a through l must be given with respect to each partner of the partnership or limited partnership, each member of the syndicate or group, and each person who controls the partner or member. If any partner, member, or person is a corporation or the person required to file the statement referred to in subsection 1 is a corporation, the commissioner may require that the information called for by subdivisions a through l must be given with respect to the corporation, each officer and director of the corporation, and each person who is directly or indirectly the beneficial owner of more than ten percent of the outstanding voting securities of the corporation.

If any material change occurs in the facts combined in the statement filed with the commissioner and sent to the insurance company pursuant to this section, an amendment setting forth the change, together with copies of all documents and other material relevant to the change, must be filed with the commissioner and sent to the insurance company within two business days after the person learns of the change. The insurance company must send the amendment to its shareholders.

3. If any offer, request, invitation, agreement, or acquisition referred to in subsection 1 is proposed to be made by means of a registration statement under the Securities Act of 1933 or in circumstances requiring the disclosure of similar information under the Securities Exchange Act of 1934, or under a state law requiring similar registration or disclosure, the person required to file the statement referred to in subsection 1 may utilize

those documents in furnishing the information called for by that statement.

4. The commissioner shall approve any merger or other acquisition of control referred to in subsection 1 unless, after a public hearing, the commissioner finds that:

a. After the change of control, the domestic insurance company referred to in subsection 1 would not be able to satisfy the requirements for the issuance of a certificate of authority to write the lines of insurance for which it is presently licensed.

b. The effect of the merger or other acquisition of control would be substantially to lessen competition in insurance in this state or tend to create a monopoly therein.

c. The financial condition of any acquiring party might jeopardize the financial stability of the insurance company, or prejudice the interest of its policyholders or the interests of any remaining securityholders who are unaffiliated with the acquiring party.

d. The terms of the offer, request, invitation, agreement, or acquisition referred to in subsection 1 are unfair and unreasonable to the securityholders of the insurance company.

e. The plans or proposals which the acquiring party has to liquidate the insurance company, sell its assets or consolidate or merge it with any person, or to make any other material change in its business or corporate structure or management, are unfair and unreasonable to policyholders of the company and not in the public interest.

f. The competence, experience, and integrity of those persons who would control the operation of the insurance company are such that it would not be in the interest of policyholders of the company and of the public to permit the merger or other acquisition of control.

The commissioner shall hold the public hearing referred to in this subsection within thirty days after the statement required by subsection 1 is filed, and shall give at least twenty days' notice to the person filing the statement. Not less than seven days' notice of the hearing must be given by the person filing the statement to the insurance company and to other persons designated by the commissioner. The insurance company must give notice to its securityholders. The commissioner shall make a

determination within thirty days after the conclusion of the hearing. At the hearing, the person filing the statement, the insurance company, any person to whom notice of hearing was sent, and any other person whose interests may be affected have the right to present evidence, examine and cross-examine witnesses, and offer oral and written arguments and in connection therewith are entitled to conduct discovery proceedings in the same manner allowed in district court of this state. All discovery proceedings must be concluded not later than three days prior to the hearing.

5. The insurance company must mail all statements, amendments, or other material filed pursuant to subsection 1 or 2, and all notices of public hearings held pursuant to subsection 4, to its shareholders within five business days after receipt by the company. The person making the filing must bear the expenses of mailing. As security for the payment of the expenses, the person shall file with the commissioner an acceptable bond or other deposit in an amount determined by the commissioner.

6. This section does not apply to:

   a. Any offers, requests, invitations, agreements, or acquisitions by the person referred to in subsection 1 of any voting security referred to in subsection 1 which, immediately prior to the consummation of such offer, request, invitation, agreement, or acquisition, was not issued and outstanding.

   b. Any transaction which is subject to the provisions of chapter 26.1-07, dealing with the merger or consolidation of two or more insurance companies.

   c. Any offer, request, invitation, agreement, or acquisition which the commissioner by order has excepted as:

      (1) Not having been made or entered into for the purpose and not having the effect of changing or influencing the control of a domestic insurance company; or

      (2) As otherwise not comprehended within the purposes of this section.

7. The following is a violation of this section:

   a. The failure to file any statement, amendment, or other material required to be filed pursuant to subsection 1 or 2.

b. The effectuation or any attempt to effectuate an acquisition of control of, or merger with, a domestic insurance company without the approval of the commissioner.

8. The courts of this state have jurisdiction over every person not resident, domiciled, or authorized to do business in this state who files a statement with the commissioner under this section, and over all actions involving the person arising out of violations of this section, and each person is deemed to have performed acts equivalent to and constituting appointment of the commissioner as the person's attorney upon whom may be served all lawful process in any action, suit, or proceeding arising out of violations of this section.

26.1-10-04. Registration - Amendments - Termination - Alternative registration - Exceptions - Disclaimer - Violation.

1. Every insurance company which is authorized to do business in this state and which is a member of an insurance holding company system must register with the commissioner, except a foreign insurance company subject to disclosure requirements and standards adopted by statute or rule in the jurisdiction of its domicile which are substantially similar to those contained in this section. Any insurance company subject to registration under this section must register before August 31, 1981, or fifteen days after it becomes subject to registration, whichever is later, unless the commissioner for good cause shown extends the time for registration, and then within the extended time. The commissioner may require any authorized insurance company which is a member of a holding company system not subject to registration under this section to furnish a copy of the registration statement or other information filed by the insurance company with the insurance regulatory authority of the domiciliary jurisdiction.

2. Every insurance company subject to registration must file a registration statement on a form approved by the commissioner, which must contain current information about:

   a. The capital structure, general financial condition, ownership, and management of the insurance company and any person in control of the insurance company.

   b. The identity of every member of the insurance holding company system.

   c. The following agreements in force, relationships subsisting, and transactions currently outstanding between the insurance company and its affiliates:

(1) Loans, other investments, or purchases, sales, or exchanges of securities of the affiliates by the insurance company or of the insurance company by its affiliates.

(2) Purchases, sales, or exchange of assets.

(3) Transactions not in the ordinary course of business.

(4) Guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the insurance company's assets to liability, other than insurance contracts entered into in the ordinary course of the insurance company's business.

(5) All management and service contracts and all cost-sharing arrangements, other than cost allocation arrangements based upon generally accepted accounting principles.

(6) Reinsurance agreements covering all or substantially all of one or more lines of insurance of the ceding company.

d. Other matters concerning transactions between registered insurance companies and any affiliates as may be included from time to time in any registration forms adopted or approved by the commissioner.

3. No information need be disclosed on the registration statement filed pursuant to subsection 2 if the information is not material for the purposes of this section. Unless the commissioner by rule or order provides otherwise, sales, purchases, exchanges, loans or extensions of credit, or investments, involving one-half of one percent or less of an insurance company's admitted assets as of December thirty-first next preceding are not material for purposes of this section.

4. Each registered insurance company must keep current the information required to be disclosed in its registration statement by reporting all material changes or additions on amendment forms approved by the commissioner within fifteen days after the end of the month in which it learns of each change or addition; provided, however, that subject to subsection 3 of section 26.1-10-05, each registered insurance company must report all dividends and other distributions to shareholders within two business days following the declaration thereof.

5. The commissioner shall terminate the registration of any insurance company which demonstrates that it no longer is a member of an insurance holding company system.

6. The commissioner may require or allow two or more affiliated insurance companies subject to registration hereunder to file a consolidated registration statement or consolidated reports amending their consolidated registration statement or their individual registration statements.

7. The commissioner may allow an insurance company which is authorized to do business in this state and which is part of an insurance holding company system to register on behalf of any affiliated insurance company which is required to register under subsection 1 to file all information and material required to be filed under this section.

8. This section does not apply to any insurance company, information, or transaction if and to the extent excepted by the commissioner by rule or order.

9. Any person may file with the commissioner a disclaimer of affiliation with any authorized insurance company or a disclaimer may be filed by the insurance company or any member of an insurance holding company system. The disclaimer must fully disclose all material relationships and bases for affiliation between the person and the insurance company as well as the basis for disclaiming the affiliation. After a disclaimer has been filed, the insurance company is relieved of any duty to register or report under this section which arises out of the insurance company's relationship with the person unless and until the commissioner disallows the disclaimer. The commissioner shall disallow the disclaimer only after furnishing all parties in interest with notice and opportunity to be heard and after making specific findings of fact to support the disallowance.

10. The failure to file a registration statement or any amendment thereto required by this section within the time specified for the filing is a violation of this section.

26.1-10-05. Standards - Transactions with affiliates - Adequacy of surplus - Dividends and other distributions.

1. Material transactions by registered insurance companies with their affiliates are subject to the following standards:

   a. The terms must be fair and reasonable.

b. The books, accounts, and records of each party must clearly and accurately disclose the precise nature and details of the transactions.

c. The insurance company's surplus as regards to policyholders following any dividends or distributions to shareholder affiliates must be reasonable in relation to the insurance company's outstanding liabilities and adequate to its financial needs.

2. For purposes of this chapter, in determining whether an insurance company's surplus as regards policyholders is reasonable in relation to the insurance company's outstanding liabilities and adequate to its financial needs, the following factors, among others, must be considered:

a. The size of the insurance company as measured by its assets, capital and surplus, reserves, premium writings, insurance in force, and other appropriate criteria.

b. The extent to which the insurance company's business is diversified among the several lines of insurance.

c. The number and size of risks insured in each line of business.

d. The extent of the geographical dispersion of the insurance company's insured risks.

e. The nature and extent of the insurance company's reinsurance program.

f. The quality, diversification, and liquidity of the insurance company's investment portfolio.

g. The recent past and projected future trend in the size of the insurance company's surplus as regards policyholders.

h. The surplus as regards policyholders maintained by other comparable insurance companies.

i. The adequacy of the insurance company's reserves.

j. The quality and liquidity of investments in subsidiaries made pursuant to section 26.1-10-02. The commissioner may treat the investment as a disallowed asset for purposes of determining the adequacy of surplus as regards policyholders whenever in the commissioner's judgment the investment so warrants.

3. An insurance company subject to registration under section 26.1-10-04 may not pay any extraordinary dividend or make any other extraordinary distribution to its shareholders until:

   a. Thirty days after the commissioner has received notice of the declaration thereof and has not within such period disapproved the payment; or

   b. The commissioner has approved the payment within the thirty-day period.

4. For purposes of this section, an extraordinary dividend or distribution includes any dividend or distribution of cash or other property, where the fair market value together with that of other dividends or distributions made within the preceding twelve months exceeds the greater of:

   a. Ten percent of the insurance company's surplus as regards policyholders as of December thirty-first next preceding; or

   b. The net gain from operations of the insurance company, if the company is a life insurance company, or the net investment income, if the company is not a life insurance company, for the twelve-month period ending December thirty-first next preceding, but may not include pro rata distributions of any class of the insurance company's own securities.

5. Notwithstanding any other provision of law, an insurance company may declare an extraordinary dividend or distribution which is conditional upon the commissioner's approval thereof, and the declaration confers no rights upon shareholders until:

   a. The commissioner has approved the payment of the dividend or distribution; or

   b. The commissioner has not disapproved the payment within the thirty-day period referred to in subsection 3.

26.1-10-06. Examination - Consultants - Expenses.

1. Subject to the limitations contained in this section and in addition to the powers which the commissioner has relating to the examination of insurance companies, the commissioner may order any insurance company registered under section 26.1-10-04 to produce any information in the possession of the insurance company or its affiliates necessary to ascertain the financial condition or legality of conduct of the insurance company. If the insurance

company fails to comply with the order, the commissioner may examine the affiliates to obtain the information.

2. The commissioner may exercise the power under subsection 1 only if the examination of the insurance company, under other provisions of the law, is inadequate or the interests of the policyholders of the insurance company may be adversely affected.

3. The commissioner may retain at the registered insurance company's expense any attorneys, actuaries, accountants, and other experts, not otherwise a part of the commissioner's staff, as are reasonably necessary to assist in the conduct of the examination under subsection 1. Any persons so retained are under the direction and control of the commissioner and shall act in a purely advisory capacity.

4. Each registered insurance company producing information for examination pursuant to subsection 1 is liable for and must pay the expense of the examination.

26.1-10-07. Information confidential. Any information obtained by or disclosed to the commissioner or any other person in the course of an examination or investigation made pursuant to section 26.1-10-06 and all information reported pursuant to section 26.1-10-04, must be given confidential treatment and is not subject to subpoena and may not be made public by the commissioner or any other person, except to insurance departments of other states, without the prior written consent of the insurance company to which it pertains unless the commissioner, after giving the insurance company and its affiliates who would be affected thereby, notice and opportunity to be heard, determines that the interests of policyholders, shareholders, or the public will be served by the publication thereof, in which event the commissioner may publish all or any part thereof in any manner the commissioner deems appropriate.

26.1-10-08. Injunctions - Prohibitions against voting securities - Sequestration of voting securities.

1. Whenever it appears to the commissioner that any insurance company or any director, officer, employee, or agent thereof has committed or is about to commit a violation of this chapter or of any rule or order issued by the commissioner under this chapter, the commissioner may apply to the district court for the county in which the principal office of the insurance company is located or if the insurance company has no principal office in this state then to the district court of Burleigh County for an order enjoining the insurance company or the director, officer, employee, or agent thereof from violating or continuing to violate this chapter or any rule or order, and for any other equitable relief as the nature of the

case and the interests of the insurance company's policyholders, creditors, and shareholders or the public may require.

2. A security which is the subject of any agreement or arrangement regarding acquisition, or which is acquired or to be acquired, in contravention of this chapter or any rule or order issued by the commissioner hereunder may not be voted at any shareholders' meeting, or may be counted for quorum purposes, and any action of shareholders requiring the affirmative vote of a percentage of shares may be taken as though the securities were not issued and outstanding, but any action taken at the meeting is not invalidated by the voting of those securities, unless the action would materially affect control of the insurance company or unless the courts of this state have so ordered. If an insurance company or the commissioner has reason to believe that any security of the insurance company has been or is about to be acquired in contravention of this chapter or any rule or order issued by the commissioner hereunder, the insurance company or the commissioner may apply to the district court of Burleigh County or to the district court of the county in which the insurance company has its principal place of business to enjoin any offer, request, invitation, agreement, or acquisition made in contravention of section 26.1-10-03 or any rule or order issued by the commissioner thereunder to enjoin the voting of any security so acquired, to void any vote of the security already cast at any meeting of shareholders, and for any other equitable relief as the nature of the case and the interests of the insurance company's policyholders, creditors, and shareholders or the public may require.

3. In any case where a person has acquired or is proposing to acquire any voting securities in violation of this chapter or any rule or order issued by the commissioner hereunder, the district court of Burleigh County or the district court of the county in which the insurance company has its principal place of business may, on the notice the court deems appropriate, upon the application of the insurance company or the commissioner seize or sequester any voting securities of the insurance company owned directly or indirectly by the person, and issue any orders with respect thereto as may be appropriate to effectuate this chapter.

4. Notwithstanding any other provision of law, for the purpose of this chapter the site of the ownership of the securities of domestic insurance companies is deemed to be in this state.

26.1-10-09. Revocation, suspension, and nonrenewal of license. Whenever it appears to the commissioner that any person has

committed a violation of this chapter which makes the continued operation of an insurance company contrary to the interests of policyholders or the public, the commissioner may, after giving notice and an opportunity to be heard, suspend, revoke, or refuse to renew the insurance company's license or authority to do business in this state for any period the commissioner finds is required for the protection of policyholders or the public. Any determination must be accompanied by specific findings of fact and conclusions of law.

26.1-10-10. Receivership. Whenever it appears to the commissioner that any person has committed a violation of this chapter which so impairs the financial condition of a domestic insurance company as to threaten insolvency or make the further transaction of business by it hazardous to its policyholders, creditors, shareholders, or the public, then the commissioner may proceed as provided in chapter 26.1-07 to take possession of the property of the insurance company and to carry on its business.

26.1-10-11. Criminal Proceedings - Penalty. Whenever it appears to the commissioner that any insurance company or any director, officer, employee, or agent thereof has committed a willful violation of this chapter, the commissioner may institute criminal proceedings in the district court of the county in which the principal office of the insurance company is located or if the insurance company has no principal office in the state, then in the district court of Burleigh County against the insurance company or the responsible director, officer, employee, or agent of the company. Any insurance company which willfully violates this chapter is guilty of a class B misdemeanor. Any individual who willfully violates this chapter is guilty of a class A misdemeanor.

26.1-10-12. Rulemaking. The commissioner may adopt rules and issue orders necessary to carry out this chapter.

SECTION 11. Chapter 26.1-11 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-11-01. Conditions to be complied with by foreign company before transacting insurance business in state. A foreign insurance company may not take any risk or transact insurance business in this state, either directly or indirectly, until it has:

1. Deposited with the commissioner a certified copy of its articles of incorporation.

2. Deposited with the commissioner a statement of its financial condition and business in the form and detail the commissioner requires, signed and sworn to by its president and secretary or other similar officers.

3. Satisfied the commissioner that it is fully and legally organized under the laws of its state or government to do the business which it proposes to transact.

4. Satisfied the commissioner, if it is a stock company, that it has a fully paid-up capital stock and surplus at least equal to the stock and surplus required of domestic companies transacting the same classes of insurance.

5. Satisfied the commissioner, if it is a mutual company, that it has complied with subsection 7 of section 26.1-12-27.

6. Satisfied the commissioner that its assets are well invested and immediately available for the payment of losses in this state and in making this determination the commissioner may rely upon the provisions pertaining to authorized investments of domestic insurance companies.

7. Satisfied the commissioner that it does not insure any single hazard for a sum larger than one-tenth of its net assets.

8. Appointed the commissioner and the commissioner's successors, by a duly executed instrument filed in the commissioner's office, its attorney upon whom all process in any action or proceeding against it may be served and has agreed in the instrument that any process that may be served upon its attorney is of the same force and validity as if the process were served on the company and that the authority thereof continues in force irrevocable so long as any liability of the company remains outstanding in this state.

9. Agreed to appoint, and will appoint, as its agents in this state only residents of this state except as otherwise provided in chapter 26-17.1.

10. Adopted a name which is not so similar to a name already in use by an existing company organized or licensed in this state as to be confusing or misleading.

26.1-11-02. Liability of officers, agents, and stockholders of noncomplying foreign company - Penalty. Any failure to comply with section 26.1-11-01 renders each officer, agent, and stockholder of any foreign insurance company failing to comply therewith jointly and severally liable on all contracts of the company made within this state during the time the company is in default. Each officer and agent of the noncomplying company is guilty of a class A misdemeanor.

26.1-11-03. Failure to comply with conditions renders contracts void on behalf of company - Enforcement against company. A contract made by or on behalf of any foreign insurance company doing business in this state without first complying with section 26.1-11-01 or 26.1-11-04 is void and unenforceable on behalf of the company and its assigns, but the contract may be enforced against the company.

26.1-11-04. Foreign life company required to maintain funds or stop writing business - Penalty. When the actual funds of any foreign life insurance company authorized to do business in this state are not of a net value equal to the net value of its policies according to the combined experience or actuaries' rate of mortality, with interest at four percent per annum, or by such higher standard as the company may have adopted, the commissioner shall give notice to the company and its agents to discontinue the issuance of new policies in this state until its funds have become equal to its liabilities when its policies are valued as provided in this section. Any officer or agent who, after notice has been given, issues or delivers a new policy from and in behalf of the company before its funds have become equal to its liabilities as provided by this section is guilty of a class A misdemeanor. This section does not apply to a cooperative or assessment life association licensed to transact business in this state.

26.1-11-05. Deposit required of foreign accident and health insurance company doing business on assessment plan. Each foreign accident and health insurance company doing business on the assessment plan in this state must keep deposited at all times with the commissioner one regular assessment sufficient in amount to pay the average loss or losses occurring among its members in this state during the time allowed by it for the collection of assessments and payment of losses. No such company may be licensed by the commissioner unless it keeps and maintains with the commissioner for the protection of persons to whom it may become obligated at least ten thousand dollars in bonds of the United States of America, of the state of North Dakota, or of political subdivisions within this state, or in mortgages on improved and unencumbered real estate within this state worth double the sum loaned thereon and approved by the commissioner.

26.1-11-06. Reciprocal penalties - Retaliatory charges. Whenever the laws of any other state, or of any foreign country, or of any province or territory thereof, or when the rules of the insurance department of that state, country, province, or territory, require any insurance company, corporation, association, or society organized under the laws of this state, or of any agent thereof, to deposit securities in that state, country, province, or territory for the protection of policyholders or others, or any payment for taxes, fines, penalties, certificates of authority, licenses, or fees, or the performance of any duties or acts other than and exceeding those required by the laws of this state of a like insurance company, corporation, association, or society, or the agents thereof, organized under the laws of that state, country, territory, or province, while transacting business in this state, then and in every such case, an insurance company, corporation, association, or society organized in that state, country, province, or territory which establishes an agency or transacts business in this state, is required to make deposits and to pay to the commissioner charges, licenses, fees, taxes, fines, or penalties in the amounts respectively, and to do all other acts which that other state, country, province, or territory, by the laws or the rules of

the insurance department thereof, requires of a like insurance company, corporation, or society, or the agents thereof, organized under the laws of this state when doing business in that other state, country, province, or territory. This section applies regardless of the plan of assessment or collection of premiums, contributions, or assessments adopted by the foreign company, corporation, association, or society.

26.1-11-07. Countersignature requirement - Commissions - Reciprocity. Notwithstanding any other provision of this title or policy forms to the contrary, there may not be any requirement that an agent resident in this state sign or countersign a policy of insurance covering a subject of insurance resident, located, or to be performed in this state. However, if the laws or rules of another state require a signature or countersignature by an agent resident in that state on a policy of insurance written by a nonresident agent or nonresident broker of that state, then any policy of insurance written by an agent resident of that state licensed as a nonresident agent in this state covering a subject of insurance resident, located, or to be performed in this state must be signed or countersigned in writing by an agent resident in this state. A policy of insurance may not be deemed invalid because of the absence of the required signature or countersignature. If the laws or rules of another state require an agent resident in that state to retain a portion of the commission paid on a like policy of insurance written, countersigned, or delivered by the agent in that state at the request of a nonresident agent or nonresident broker of that state, then the agent resident in this state who signed or countersigned a policy of insurance written by a resident of that state licensed as a nonresident agent in this state covering a subject of insurance resident, located, or to be performed in this state shall retain an equal pro rata portion of any commission on the policy of insurance.

26.1-11-08. Grounds for revocation of authority of foreign company. The commissioner shall revoke or suspend all certificates of authority granted to a foreign insurance company or to its agents if, upon examination or other evidence, the commissioner is of the opinion that:

1. The company is in an unsound condition.

2. The company has failed to comply with any provision of the applicable laws of this state.

3. The company, or any officer or agent thereof, has refused to submit to examination or to perform any other legal obligation.

26.1-11-09. Procedure for suspension or revocation of foreign company's authority - Effect. Whenever it appears to the commissioner, either upon complaint or otherwise, that any foreign insurance company is in violation of section 26.1-02-23 or 26.1-11-08, the commissioner may issue a temporary order suspending the certificate of authority

granted to a foreign insurance company if the commissioner deems it necessary or appropriate to the public interest to do so. Any company aggrieved by a temporary order may request a hearing before the commissioner within ten days after the company receives the order. If the commissioner revokes the certificate of authority granted to a foreign insurance company, the commissioner shall publish a notice of revocation once each week for three successive weeks in a newspaper published at the state capital. Thereafter, no new business may be done by the company, or by its agents, in this state until its certificate of authority is restored by the commissioner. The commissioner, after a hearing and for good cause, may cancel the revocation and restore the certificate.

26.1-11-10. Consent to service of process. Service of process upon the commissioner as attorney for a foreign insurance company doing business in this state is sufficient service upon the company.

26.1-11-11. Consent to service of process - Unauthorized insurance company. Any of the following acts in this state, effected by mail or otherwise, by any unauthorized foreign or alien insurance company is equivalent to and constitutes an appointment by the company of the commissioner as its attorney upon whom may be served all lawful process in any action, suit, or proceeding instituted by or on behalf of an insured or beneficiary arising out of any contract of insurance, and any such act signifies its agreement that the service of process is of the same legal force and validity as personal service in this state, upon such insurer:

1. The issuance or delivery of contracts of insurance to residents of this state or to corporations authorized to do business in this state.

2. The solicitation of applications for such contracts.

3. The collection of premiums, membership fees, assessments, or other considerations for such contracts.

4. Any other transaction of insurance business.

26.1-11-12. Additional means of service.

1. Service in any action, suit, or proceeding is, in addition to the manner provided in section 26.1-01-04, valid if served upon any person within this state who on behalf of the insurance company is:

   a. Soliciting insurance;

   b. Making, issuing, or delivering any contract of insurance; or

   c. Collecting or receiving any premium membership fee, assessment, or other consideration for insurance.

2. A copy of the process must be sent within ten days thereafter by registered mail by the plaintiff or the plaintiff's attorney, to the defendant at the defendant's last known principal place of business.

3. The defendant's receipt, or the receipt issued by the post office with which the letter is registered or certified, showing the name of the sender of the letter, the name and address of the person to whom the letter is addressed, and the affidavit of the person mailing the letter showing a compliance herewith must be filed with the clerk of the court in which the action is pending on or before the date the defendant is required to appear or within such further time as the court allows.

26.1-11-13. Right of service not abridged. This chapter does not limit or abridge the right to serve any process, notice, or demand upon any insurance company in any other manner permitted by law.

26.1-11-14. Judgment by default - Time of entry. A judgment by default under this chapter may not be entered until the expiration of thirty days from the date of the filing of the affidavit of compliance.

26.1-11-15. Defense of action by unauthorized company. Before any unauthorized foreign or alien insurance company may file or cause to be filed any pleading in any action, suit, or proceeding instituted against it, the company must deposit with the clerk of the court in which the action, suit, or proceeding is pending, cash or securities, or file with the clerk a bond with good and sufficient sureties approved by the court in an amount fixed by the court sufficient to secure the payment of any final judgment which may be rendered in the action. The court may, in its discretion, dispense with the deposit or bond where the company makes a showing satisfactory to the court that it maintains in the United States funds or securities, in trust or otherwise, sufficient and available to satisfy any final judgment which may be entered in the action, suit, or proceeding, and that the company will pay any final judgment rendered without requiring suit to be brought on the judgment in the state where the securities are located, or procure a certificate of authority to transact insurance business in this state.

26.1-11-16. Court may order postponement. The court in any action, suit, or proceeding in which service is made in the manner provided in section 26.1-01-04 or 26.1-11-12, may order any postponement necessary to afford the defendant reasonable opportunity to comply with this chapter and to defend the action.

26.1-11-17. Construction. Section 26.1-11-16 does not prevent an unauthorized foreign or alien insurance company from filing a motion to quash a writ or to set aside service thereof made in the manner provided in this chapter on the ground that the company has not done any of the acts enumerated in this chapter or that the person on

whom service was made pursuant to section 26.1-11-12 was not doing any of the acts therein enumerated.

26.1-11-18. Attorney's fees. In any action against an unauthorized foreign or alien insurance company upon a contract of insurance issued or delivered in this state to a resident of this state or to a corporation authorized to do business in this state, if the insurance company has failed for thirty days after demand prior to the commencement of the action to make payment in accordance with the terms of the contract, and it appears to the court that refusal was vexatious and without reasonable cause, the court may allow to the plaintiff a reasonable attorney's fee and include the fee in any judgment that may be rendered in the action. The fee may not exceed twelve and one-half percent of the amount which the court or jury finds the plaintiff is entitled to recover against the insurance company, but the fee awarded may not be less than twenty-five dollars. Failure of an insurance company to defend any action is prima facie evidence that its failure to make payment was vexatious and without reasonable cause.

26.1-11-19. Application. This chapter does not apply to any action, suit, or proceeding against any unauthorized foreign or alien insurance company arising out of any contract of reinsurance, ocean marine, aircraft or railway insurance, insurance against legal liability arising out of the ownership, operation or maintenance of any property having a permanent situs outside this state, or insurance against loss of or damage to any property having a permanent situs outside this state, where the contract of insurance designates the commissioner or a bona fide resident of this state the attorney of the unauthorized insurance company upon whom may be served all lawful process in any action, suit, or proceeding instituted by or on behalf of an insured or beneficiary arising out of the contract or where the insurance company enters a general appearance in the suit, action, or proceeding.

SECTION 12. Chapter 26.1-12 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-12-01. Organization of mutual insurance company - Minimum number of members. Any number of persons, not less than twenty, a majority of whom must be bona fide residents of this state, may become, together with others who thereafter may be associated with them or their successors, a body corporate for the purpose of carrying on the business of mutual insurance as provided in this chapter by complying with this chapter.

26.1-12-02. Corporate name - Restrictions. The name of a mutual insurance company organized under this chapter must contain the word "mutual". A name which is so similar to any name already in use by any existing corporation, company, or association organized or doing business in this state as to be confusing or misleading is not permitted.

26.1-12-03. Articles of incorporation - Contents. Persons proposing to form a mutual insurance company under this chapter shall subscribe and acknowledge articles of incorporation specifying:

1. The name of the company and the purpose for which it is to be formed.
2. The location of its principal or home office, which must be within this state.
3. The names and addresses of those composing the board of directors in which the management is vested until the first meeting of the members.
4. The names and places of residence of the incorporators.
5. The term of existence of the company, which may not exceed thirty years.

26.1-12-04. Articles of incorporation - Filing - Issuance of certificate. The articles of incorporation or amendments thereto of a mutual insurance company organized under this chapter must be submitted to the commissioner and to the attorney general. If the commissioner and the attorney general determine the articles or amendments comply with this chapter, the commissioner shall approve the same. The articles or amendments must be filed in the office of the secretary of state and a certified copy must be filed with the commissioner. The commissioner shall deliver a certificate to the company indicating that it has complied with this chapter.

26.1-12-05. Legal existence - Adoption of bylaws - Transaction of business. The mutual insurance company has legal existence as of the date of the certificate. The board of directors named in the articles thereafter may adopt bylaws which must be filed with the commissioner, accept applications for insurance, and proceed to transact company business. Insurance may not be put into force, however, until the company has been licensed to transact an insurance business as provided by this chapter.

26.1-12-06. Bylaws of mutual company - Meetings - Notice - Quorum. The bylaws of any mutual insurance company organized under this chapter or chapter 26.1-05, must prescribe the manner of notification to members of all corporation meetings of members and must prescribe what constitutes a quorum of members. A quorum is those members present in person or represented by written proxies. A majority of those voting is sufficient to approve or reject any proposal submitted at any annual or special meeting. Every member of the company is entitled to one vote only. Every member must be notified of the time and place of the holding of the meetings of the company by a written notice or by an imprint on the back of each policy, receipt, or certificate of renewal. In addition a notice of any annual or special meeting must be published in the official newspaper of the county in which the principal office of the company is located. The notice must be published at least twice, the first

publication to be made at least sixty days before the meeting. If a special meeting of members is called, a notice of the time, place, and object of the meeting must be mailed to all members at least sixty days before the meeting.

26.1-12-07. Amendment of articles of incorporation - Amendment of bylaws - Extension of corporate existence. The articles of incorporation of a mutual insurance company organized under this chapter may be amended, its term of corporate existence extended, and its bylaws adopted, amended, or repealed at any annual meeting of the company, or at any special meeting called for that purpose, by the affirmative vote of two-thirds of the members voting on the proposition.

26.1-12-08. License required - Prerequisites to issuance of license. A mutual insurance company organized under this chapter may not issue policies or transact any insurance business unless it holds a license from the commissioner authorizing the transaction of insurance business. The license may not be issued unless and until the company complies with the following conditions:

1. It must hold bona fide applications for insurance upon which it will issue simultaneously at least twenty policies to at least twenty members for the same kind of insurance upon not less than two hundred separate risks, each within the maximum single risk.

2. The "maximum single risk" may not exceed twenty percent of the admitted assets of the company, or three times the average risk, or one percent of the insurance in force, whichever is the greater, any reinsurance taking effect simultaneously with the policy being deducted in determining the maximum single risk.

3. It must have collected a premium upon each application. All premiums must be held in cash or in securities in which insurance companies may invest, and in the case of fire insurance, must be equal to not less than twice the maximum single risk assumed subject to one fire nor less than ten thousand dollars, and in any other kind of insurance as listed in section 26.1-12-11, to not less than five times the maximum single risk assumed nor less than ten thousand dollars.

4. It must maintain a surplus of at least five hundred thousand dollars, except if the minimum assets and surplus requirements for the company are more than the minimum requirements provided by this subsection at the time the company was originally issued a license to do business, the company may maintain assets and surplus which satisfy the requirements in effect at that time.

26.1-12-09. Temporary capital on organization of mutual life company - Retirement. A mutual life insurance company may be organized with,

and an existing mutual life insurance company may establish, a temporary capital of not less than one hundred thousand dollars which must be invested in the manner provided for the investment of its other funds. Out of the net surplus of the company, the holders of the temporary capital stock may receive a dividend of not more than eight percent per annum, and the dividend may be cumulative. The capital stock may not be a liability of the company except that it must be retired as soon as, but not before, the surplus of the company remaining after its retirement will equal at least the amount of the temporary capital. At the time for the retirement of the capital stock, the holders must receive from the company the par value thereof and any dividends thereon due and unpaid, and the stock must be surrendered and canceled, and the right to vote thereon ceases.

26.1-12-10. Mutual life company - Amount of subscribed insurance required - Surplus required. A mutual life insurance company may not issue a policy until not less than two hundred thousand dollars of insurance in not less than two hundred separate risks have been subscribed for and entered on its books. The commissioner may not issue a certificate of authority for the transaction of business to the company unless it has a surplus of assets over all liabilities of at least five hundred thousand dollars. A domestic mutual life insurance company must maintain surplus of at least this amount. If the minimum asset and surplus requirements required by this section are more than the minimum requirements required at the time a company was issued its original certificate of authority, the company must maintain assets and surplus which satisfy the assets and surplus requirements in effect at that time.

26.1-12-11. Authority to insure or reinsure - Kinds of insurance open to mutual company. Any mutual insurance company organized under this chapter may make contracts of insurance, and may reinsure or accept reinsurance on any portion thereof, to the extent specified in its articles of incorporation, for the following kinds of insurance:

1. Fire, hail, lightning, tornado, and other insurance. Against loss or damage to property, and the loss of use and occupancy thereof, by fire, lightning, hail, tempest, flood, earthquake, frost or snow, explosion with fire ensuing, and explosion with no fire ensuing, except explosion by steam boilers or flywheels; against loss or damage by water caused by the breakage or leakage of sprinklers, pumps or other apparatus, water pipes, plumbing, or their fixtures, erected for extinguishing fires, and against accidental injury to the sprinklers, pumps or other apparatus, water pipes, plumbing, or fixtures; against the risks of inland transportation and navigation; upon automobiles, whether stationary or operated under their own power, against loss or damage by any of the causes or risks specified in this subsection, including also transportation, collision, liability for damage to property resulting from owning, maintaining, or using automobiles, and including burglary and theft, but

not including loss or damage by reason of bodily injury to the person.

2. Liability insurance. Against loss, expense, or liability by reason of bodily injury or death by accident, disability, sickness, or disease suffered by others for which the insured may be liable or may have assumed liability.

3. Disability insurance. Against bodily injury or death by accident and disability by sickness.

4. Automobile insurance. Against any or all loss, expense, and liability resulting from the ownership, maintenance, or use of any automobile or other vehicle. A policy may not be issued under this subsection against the hazard of fire alone.

5. Steam boiler insurance. Against loss or liability to persons or property resulting from explosions or accidents to boilers, containers, pipes, engines, flywheels, and elevators and machinery used in connection therewith, and against loss of use and occupancy caused thereby. If the company issues insurance under this subsection, it may make inspections and issue certificates of inspection.

6. Use and occupancy insurance. Against loss from interruption of trade or business which may be the result of any accident or casualty.

7. Miscellaneous insurance. Against loss or damage by any hazard upon any risk not provided for in this section which is not prohibited by statute or at common law from being the subject of insurance, except life insurance.

8. Legal expense insurance.

26.1-12-12. Compliance with general insurance laws - Provisions or conditions in policy. A mutual insurance company organized under this chapter must comply with the provisions of any law applicable to a stock insurance company effecting the same kind of insurance. A company may insert in any form of policy prescribed by the law of this state any provisions or conditions required by its plan of insurance which are not inconsistent or in conflict with the law of this state. The policy may conform to the language and form prescribed by the law, if the policy includes a provision or endorsement reciting that the policy is to be construed as if it were in the language and form prescribed by the law and if a copy of the policy and endorsement, if any, first have been filed with, and not disapproved by, the commissioner.

26.1-12-13. Applicability of general insurance laws to mutual companies. In all respects not specifically provided for in this chapter, mutual insurance companies organized under this chapter are subject

to the provisions of this title relating to insurance companies generally.

26.1-12-14. Membership in domestic mutual company - Votes of members - Notice of meetings. Every member insured by a domestic mutual insurance company organized under this chapter is a member of the company while the policy is in force. Every member of the company is entitled to one vote or to a number of votes based upon the insurance in force, the number of policies held, or the amount of premiums paid, as may be provided in the bylaws of the company. Every member must be notified of the time and place of the holding of the meetings of the company by a written notice or by an imprint on the back of each policy, receipt, or certificate of renewal as follows:

> The assured is hereby notified that by virtue of this policy the assured is a member of ---------- mutual insurance company, and that the annual meetings of such company are held at its home office on the -------- day of ---------- in each year at ----- o'clock.

When the blanks in the notice are properly filled, the notice is sufficient.

26.1-12-15. Corporations, associations, boards, and estates may become member of mutual company - Rights and liabilities. Any public or private corporation, board, or association in this state or elsewhere may make applications and enter into agreements for, and hold, policies in any mutual insurance company organized under this chapter. Any officer, stockholder, trustee, or legal representative of the corporation, board, association, or the representative of an estate may be recognized as acting for or on its behalf for the purpose of the membership but is not liable personally upon the contract of insurance by reason of acting in the representative capacity. The right of any corporation organized under the laws of this state to participate as a member of any mutual insurance company is declared to be incidental to the purpose for which the corporation is organized and granted as fully as the rights and powers expressly conferred upon it.

26.1-12-16. Vote by proxy permitted - Manner of voting by proxy. Members of a mutual insurance company may vote by proxy dated and executed within three months prior to the meeting at which the proxy is to be used when returned and recorded on the books of the company three days or more before the meeting. A person may not as proxy or otherwise cast more than fifty votes, and an officer, personally or by another, may not ask for, receive, procure to be obtained, or use, a proxy vote. This section does not apply to state mutual hail insurance companies.

26.1-12-17. Members of mutual company entitled to share of net profits. Every member of a mutual insurance company, except a mutual life insurance company, when the member's policy expires, is entitled to

be paid in cash the member's share of the net profits or surplus accrued while the policy was in force.

26.1-12-18. Premiums and contingent liabilities to be stated in bylaws and on policy - Collection of premiums. A mutual insurance company, other than a mutual life company, must charge and collect the full mutual premium upon its policies in cash or in the form of a note. It may fix in its bylaws the contingent mutual liability of its members for the payment of losses and expenses not provided for by the cash funds of the company, but the contingent liability of a member, if any, may not be less than a sum equal, and in addition to, the cash premium written in the policy. The total amount of the liability of a policyholder must be stated clearly and legibly upon the face of each policy. A policy may not be issued for a cash premium without an additional contingent premium unless the company has a surplus which is not less in amount than the surplus required of domestic stock insurance companies transacting the same kinds of insurance.

26.1-12-19. Nonpayment of premiums and contingent liabilities - Effect - Continuation of liability on mortgage clause policy. If the premium on a policy issued by a mutual insurance company is not paid in cash or in an unconditional note within sixty days after the date of issue of the policy, the policy becomes void and remains void during the period of nonpayment of premium. Upon the payment of the premium, the policy reattaches if no loss has occurred thereunder while the policy was void. If, however, the company has issued a policy with a mortgage clause making loss, if any, payable to the mortgagee to the extent of the mortgagee's interest and not exceeding the amount of the policy, the company, notwithstanding the nonpayment of premium or contingent mutual liability, is liable on the policy to the mortgagee until the secretary of the company has notified the mortgagee in writing that the premium or contingent mutual liability has not been paid and the mortgagee has twenty days from the date of the notice in which to pay the same, and in default of the payment, the liability of the company to the mortgagee ceases.

26.1-12-20. Separate reserves to be maintained for each kind of insurance written by mutual company. Every mutual insurance company organized under this chapter must maintain unearned premium and other reserves separately for each kind of insurance written by it upon the same basis as is required of a domestic stock insurance company transacting the same kind of insurance business. Any reserve for losses or claims based upon the premium income, however, must be computed upon the net premium income after deducting any so-called dividend or premium returned or credited to the member.

26.1-12-21. Reserve fund may be established - Limitation - Use. Any mutual insurance company, at a meeting called for that purpose, may provide for the accumulation of a permanent fund, in an amount determined from time to time by the board of directors, by reserving a portion of the net profits for investment as a reserve for the security of the policyholders. When the fund amounts to five percent of the sum insured by all policies in force, the whole of the net profits thereafter must be divided among the insureds in

cash as provided in the bylaws of the company. The fund must be used for the payment of losses and expenses whenever the cash funds of the company in excess of an amount equal to its liabilities are exhausted.

26.1-12-22. Investments. A mutual insurance company organized under this chapter may invest its assets only in accordance with the provisions of the laws of this state relating to the investment of the assets of domestic stock companies transacting the same kind or kinds of insurance business.

26.1-12-23. Deficiency in assets - Assessments required. A mutual insurance company not possessed of assets at least equal to its unearned premium reserve and other liabilities must make an assessment upon its members liable to assessment to provide for the deficiency. The assessment must be made against each such member in proportion to the member's liability as expressed in the member's policy. The commissioner, however, may relieve the company, by written order, from any assessment or other proceedings to restore the assets during the time fixed in the order. The company must record in a book kept for that purpose the order for the assessment and a statement setting forth the condition of the company at the date of the order, the amount of its cash assets and of the notes of its policyholders or of other contingent funds liable to the assessment, the amount of the assessment, and the particular losses or other liabilities for which the assessment is made. The record must be made and signed by the directors who voted for the order before any part of the assessment is collected, and any person liable for the assessment may inspect and take a copy of the record.

26.1-12-24. Making premium reserve good - Assessments - Cancellation of policies - Reinsurance. When, by reason of depreciation or loss of its funds or otherwise, the cash assets of a mutual insurance company, after providing for its other debts, are less than the required premium reserve upon its policies, it must make good the deficiency by assessment in the mode provided in section 26.1-12-23. If the directors are of the opinion that the company is likely to become insolvent, the board of directors, instead of the assessment, may make two assessments, the first determining what each policyholder must equitably pay or receive in case of withdrawal from the company and having the policy canceled and the second determining what further sum each must pay in order to reinsure the unexpired term of the policy at the rate at which the whole was insured at first. Each policyholder subject to assessment shall pay or receive according to the first assessment, and the policy then must be canceled unless the policyholder pays the further sum determined by the second assessment, in which case the policy continues in force. In neither case, however, may a policyholder receive or have credited more than the policyholder would have received on having the policy canceled by a vote of the board of directors under the bylaws. If, within two months after the alternative assessments have become collectible, the amount of the policies whose holders have settled for both assessments is less than two hundred thousand dollars, the company must stop issuing policies. All policies the

holders of which have not settled for both assessments are void, and the company may continue only for the purpose of adjusting the deficiency or excess of premiums among the members and settling outstanding claims. No assessment is valid against a person who has not been notified thereof within two years after the expiration or cancellation of the policy.

26.1-12-25. Directors and treasurer of mutual company personally liable for not making and collecting assessments. If the directors of any mutual insurance company neglect or omit for the space of six months to lay, or to use reasonable diligence to collect, any assessment which the board of directors is required to make, they are liable personally for all debts and claims then outstanding against the company or that may accrue until the assessment is laid and put in process of collection. If the treasurer of the company unreasonably neglects to collect an assessment made by order of the board of directors and to apply the assessment to the payment of the claims for which it was made, the treasurer is liable personally to the parties having the claims for the amount of the assessment. The treasurer may repay oneself out of any money afterwards received for the company on account of the assessment.

26.1-12-26. Advance to mutual company - Repayment - Reporting - Commission or promotion expense. Any director, officer, or member of a mutual insurance company, or any other person, may advance to the company any sum of money necessary for the purpose of its business or to enable it to comply with any of the requirements of the law, and such moneys, together with any interest agreed upon, but not exceeding the maximum contract rate, is not a liability or claim against the company or any of its assets and may be repaid only out of the surplus earnings of the company. A commission or promotional expense may not be paid in connection with the advance to the company. The amount of any advance must be reported in each annual statement.

26.1-12-27. Licensing foreign mutual company - Prerequisites. Any mutual insurance company organized outside of this state and authorized to transact insurance business on the mutual plan in any state, district, or territory must be admitted and licensed to transact the kinds of insurance authorized by its charter or articles, to the extent and with the powers and privileges specified in this chapter and subject to all the provisions of law relating to information to, and examinations by, the commissioner, the making of annual reports, the payment of taxes, and the renewal of licenses applicable to stock insurance companies transacting the same kinds of insurance business except as otherwise provided in this chapter, when it is solvent under this chapter and when it has:

1. Filed with the commissioner a certified copy of its charter or articles of association;

2. Filed with the commissioner a copy of its bylaws certified by its secretary;

3. Appointed the commissioner its agent for the service of process in any action, suit, or proceeding in any court of this state, for as long as any liability remains outstanding in this state;

4. Filed a financial statement under oath, in the form required by the commissioner, and complied with other provisions of law applicable to the filing of papers and furnishing information by stock companies on application for authority to transact the same kind of insurance business;

5. Made and maintained, if organized without the United States, the deposit required of stock insurance companies formed without the United States transacting the same kinds of insurance business;

6. Adopted a name which is not so similar to a name already in use by an existing corporation, company, or association organized or licensed in this state as to be confusing or misleading; and

7. Accumulated assets in excess of all of its liabilities in an amount not less than five hundred thousand dollars, except if the minimum surplus requirement for the company is more than the minimum requirement provided by this subsection at the time the company was originally issued a license to do business, the company may maintain surplus which satisfies the requirements effect at that time.

26.1-12-28. Annual statements and examinations of mutual companies. Every mutual insurance company doing business in this state must make its annual statement and report in the form and submit to the examinations and furnish the information required by the commissioner. As far as practicable, examinations of foreign mutual insurance companies must be made in cooperation with the insurance departments of other states, and the forms of annual reports must be such as are in general use throughout the United States.

26.1-12-29. Dividends payable by mutual company. Any mutual insurance company writing fire, accident, or other forms of insurance protection on its own motion or at the request of policyholders may pay dividends to the different classes of policyholders based upon the losses sustained as compared with the income received from those engaged in a particular trade, occupation, or profession.

26.1-12-30. Determination of dividends. In determining the rate of dividend due a given trade, occupation, or profession, if the dividend is allowed, the income received and losses sustained must be tabulated for a period of not less than five years immediately preceding the determination of the dividend rate, and the return dividend to policyholders must be based upon the experience of such

period after deduction for expenses and allowances for reserves as required by law.

26.1-12-31. Taxable premiums of mutual company. For the purposes of taxation under the laws of this state, the taxable premiums or premium receipts of a mutual insurance company organized or admitted to do business in this state are the gross premiums received for direct insurance upon property or risks in this state less:

1. Any amount paid for reinsurance upon which a tax has been, or is to be, paid to this state.
2. Premiums upon policies not accepted.
3. Premiums returned on canceled policies.
4. Any refund or return made to the policyholder other than for losses.

SECTION 13. Chapter 26.1-13 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-13-01. County mutual insurance company - Organization. A corporation for mutual insurance may be formed in accordance with this chapter by any number of persons, not less than fifty, residing in not more than ten counties in this state, who collectively own property of not less than one hundred thousand dollars in value which they desire to insure; or any number of persons, not less than twenty-five, residing in any one county in this state, who collectively own property of not less than twenty-five thousand dollars in value which they desire to insure.

26.1-13-02. Articles of incorporation - Insurance applications required. Persons desiring to form a county mutual insurance company must submit to the commissioner and to the attorney general the articles of incorporation of the proposed company. If the articles are found to comply with this chapter, the commissioner shall approve the articles and the articles must be filed in the office of the secretary of state and a certified copy must be filed with the commissioner. The articles must be signed by the number of persons required to incorporate the company and must be accompanied by sufficient evidence of the execution of bona fide applications for insurance to the number and in the amount stated in section 26.1-13-01. The articles of incorporation must set forth:

1. The name of the company.
2. The name of the city in or near which the business office of the company is to be located.
3. The intended duration of the company, which is perpetual.

26.1-13-03. County mutual company has perpetual existence. Every county mutual insurance company has perpetual existence. If the

articles of incorporation of any company show that the existence of the company is other than perpetual, the articles may be amended in the manner provided by law so as to extend the term of existence of the corporation to show that it is perpetual.

26.1-13-04. Certificate of compliance. After articles of incorporation have been approved and filed, the commissioner shall deliver to the persons filing the articles a certificate to the effect that the county mutual insurance company has complied with all of the requirements of law. The certificate constitutes the authority of the company to commence business and issue policies. A certified copy of the articles and the certificate may be used for or against the company with the same effect as the original and are conclusive evidence of the fact of the organization of the company as of the date of the certificate.

26.1-13-05. Bylaws - Contents. A county mutual insurance company may make bylaws, not inconsistent with the constitution or laws of this state, necessary to provide for the management of its affairs in accordance with this chapter and to prescribe the duties of its officers and fix their compensation. Bylaws may be repealed or amended in the manner provided in this chapter.

26.1-13-06. Amendment of articles or bylaws. The articles of incorporation of a county mutual insurance company may be amended, and its bylaws adopted, amended, or repealed, at any annual meeting of the company, or at any special meeting called for that purpose, by the affirmative vote of two-thirds of the members voting on the proposition.

26.1-13-07. Directors - Number - Election - Powers and duties. The general management of the business of a county mutual insurance company must be vested in a board of directors consisting of not less than five members nor more than fifteen members. The members of the board must be elected by the members of the company at the annual meeting in the manner provided by the bylaws of the company and if it is not otherwise provided, by ballot. As nearly as may be, one-third of the members of the first board must be elected for one year, one-third for two years, and one-third for three years, and in all elections subsequent thereto, except in the case of elections to fill vacancies on the board, members must be elected for terms of three years. Each director holds his office until a successor is elected and qualified. In the election of the members of the first board, each incorporator is entitled to one vote, and at every subsequent election each member of the company is entitled to one vote. The board may exercise the usual powers and must perform the usual duties of a board of directors of a corporation generally.

26.1-13-08. Officers - Election - Bond. The board of directors must elect a president and a vice president from the board and must select a secretary and a treasurer who may or may not be members of the company. The offices of secretary and of treasurer may be held by one person. The secretary and the treasurer shall give bonds to

the company for the faithful performance of their respective duties in any amounts prescribed by the board. Each officer holds office for one year and until a successor is elected and qualified.

26.1-13-09. Membership in county mutual company - Limitation on right to be director. Any person owning property within the limits of the territory within which a county mutual insurance company is authorized to transact business may become a member of the company and entitled to all of the rights and privileges appertaining thereto by insuring therein. A person who does not reside within the territorial limits may not become a director of the company.

26.1-13-10. Members of county mutual company - Policyholders - Notice of meetings. Every person insured by a county mutual insurance company is a member while the policy is in force. The member is entitled to one vote only, and must be notified of the time and place of the holding of the meetings of the company by written notice thereof or by an imprint on the face of each policy, receipt, or certificate of renewal, as follows:

> The assured is hereby notified that by virtue of this policy the assured is a member of the ---------- mutual insurance company, and that the annual meetings of the company are held at its home office on the ---------- day of ---------- in each year at ---------- o'clock.

When the blanks in the notice are properly filled, the notice is sufficient.

26.1-13-11. Annual meeting - Quorum. The annual meeting of a county mutual insurance company must be held on the second Thursday in March in each year unless it is provided otherwise in the bylaws of the company. Twenty members constitute a quorum for the transaction of business at an annual meeting.

26.1-13-12. General powers, liabilities, and duties of county mutual company - Office - Name - Limitations. A county mutual insurance company possesses the powers and is subject to the liabilities and duties of other insurance companies, except that:

1. The principal office of the company must be located within the limits of the county or counties in which the incorporators reside.

2. When the company is organized by the residents of a single county, the name of the county together with the word "county" must be embraced in the corporate name of the company.

3. Any company organized under this chapter for mutual protection against loss or damage by tornadoes, windstorms, cyclones, hail, except upon growing crops, and any hazard upon any risk upon livestock, only, may operate and issue policies in all of the counties of the state,

but in all other matters is regulated and limited by this chapter.

26.1-13-13. Applicability of general insurance laws. In all respects not specifically provided for in this chapter, county mutual insurance companies are subject to the provisions of this title relating to insurance companies generally.

26.1-13-14. County mutual company - Insurance authority. A county mutual insurance company may insure against loss or damage by fire, lightning, cyclone, windstorm, tornado, hail, except upon growing crops, any hazard upon any risk upon livestock, explosion, except the explosion of steam boilers and flywheels, riot, riot attending a strike, civil commotion, aircraft, vehicles, smoke to the property of the insured, theft, vandalism, malicious mischief, water damage and freezing, collision and overturn of farm machinery, collapse of buildings, glass breakage, the additional living expenses incurred over and above normal living costs in cases of damage, the removal of debris, the cost or repairing or replacing homes or living residences, or all such forms of insurance.

26.1-13-15. Territorial limits of county mutual company's operations - Terms of policies - Property insurable. A county mutual insurance company may not insure any property beyond the limits of the territory comprised in the formation of the company except as provided in subsection 3 of section 26.1-13-12 and except that this territorial limitation does not apply to reinsurance contracts. A policy may not be issued to exceed five years. A policy may not be issued covering property located within the platted limits of any incorporated city in this state, except that a policy may be issued providing coverage on the actual place of residence occupied by the policyholder and appurtenant structures and the contents thereof as specified in sections 26.1-13-14 and 26.1-13-16 to existing members within the platted limits of any incorporated city in this state. The company may insure all property located outside of incorporated cities in this state.

A policy issued by the company, if it so provides, may cover loss or damage to livestock, personal property, vehicles, and farm machinery while temporarily removed from the premises of the insured to other locations.

26.1-13-16. Liability insurance contracts - Limitations. Any county mutual insurance company may make contracts of insurance against loss, expense, or liability by reason of bodily injury or death by accident, disability, sickness, or disease suffered by others for which the insured may be liable or may have assumed liability, except no liability insurance contracts against any or all loss or expense resulting from the ownership, maintenance, or use of any motor vehicle normally operated, intended to be operated, or designed for use, upon any highway, road, or street in this state, may be made.

26.1-13-17. Classification of property for insurance purposes. A county mutual insurance company may classify the property insured by the policies at the time of issuance under different rates corresponding, as nearly as may be, to the greater or lesser risk from fire or lightning and loss which may attach to each of the buildings insured.

26.1-13-18. Maximum amount of insurance on single risk. The maximum amount of insurance which a county mutual insurance company may retain on a single risk other than under a liability insurance contract, after deduction of applicable reinsurance, may not exceed ten percent of the admitted assets of the company or thirty thousand dollars, whichever is the larger amount. The maximum amount of insurance which a county mutual insurance company may retain on a single risk under a liability insurance contract may not exceed one percent of the surplus maintained by the company.

26.1-13-19. Reinsurance of excessive losses. Except as otherwise provided in sections 26.1-02-20 and 26.1-02-22, any county mutual insurance company may reinsure in a single contract, with other county mutual insurance companies, against excessive losses on all contracts of insurance written. The reinsurance contracts may provide:

1. That whenever the total losses per dollar of insurance in force of any county mutual insurance company joining the contract exceeds the average total losses per dollar of insurance in force of all county mutual insurance companies joining the contract, the excessive loss or a portion thereof must be paid to the county mutual insurance company or companies suffering the excessive loss by the companies having a lower than average loss ratio; and

2. That the payments by individual companies suffering a lower than average loss ratio must be prorated according to a formula based upon the total dollars of insurance in force of any participating company as compared to the total dollars of insurance in force of all participating companies suffering a lower than average loss ratio.

The payments by any single company may not be greater than that sum which would bring the loss ratio per dollar of insurance in force of the company up to the average loss per dollar of insurance in force of all participating companies.

26.1-13-20. Designation of attorney in fact - Assessments. Companies participating in a reinsurance contract must designate an attorney in fact who must calculate the average loss per dollar of insurance in force for each participating company and the average loss per dollar of insurance in force of all participating companies at regular intervals. The attorney in fact must also prorate and assess the excessive losses against the participating companies in the manner provided in section 26.1-13-19 and collect the

assessments and pay them over to the companies suffering the excessive losses. The participating companies may pay the assessments out of reserves or a company may assess its individual members in the manner provided for other ordinary losses. Each participating company must pay an agreed advance premium sufficient to pay all administrative expenses of the attorney in fact.

26.1-13-21. Supervision by commissioner. The commissioner has full power of supervision over all reinsurance contracts executed under sections 26.1-13-19 and 26.1-13-20.

26.1-13-22. Insured to give undertaking to pay pro rata share of losses - Cash payment or premium required. Every person insured by a county mutual insurance company shall give an undertaking, bearing the date the policy was issued, binding the person, the person's heirs and assigns, to pay to the company the person's pro rata share of all losses or damages as specified in sections 26.1-13-14 and 26.1-13-16 which may be sustained by any member. The undertaking must be filed with the secretary in the office of the company before the issuance of the policy, and must remain on file in the office except when it is required to be produced as evidence in court. The person also, at the time of receiving the insurance, shall pay in cash the percentage or any reasonable sum named in the policy as may be required by the rules and bylaws of the company, or pay premiums as provided in section 26.1-13-25.

26.1-13-23. Loss - Notice - Adjustment - Arbitration - Finality of determination of board of adjustment - Powers of board. Every member of a county mutual insurance company who sustains loss or damage by fire, lightning, or cyclone shall notify the secretary of the company, or the president in the absence of the secretary, immediately after the loss is sustained. That officer shall ascertain the amount of the loss and shall cause the amount of the loss to be adjusted in the manner provided in the bylaws of the company, or the officer forthwith shall convene the board of directors of the company, and, the board must appoint a committee of not more than three members of the company to ascertain and adjust the amount of the loss. If the parties are unable to agree upon the amount of the damage, the claimant and the company each must choose a disinterested party, to constitute a board of arbitration to settle the loss. If the parties cannot agree, they shall choose a third party to act with them. The board of arbitration may examine witnesses and must determine all matters in dispute, and the decision of the board is final. Any officer or member of the company, while acting as an adjuster, and the members of any board of arbitration appointed pursuant to this section, may subpoena and examine witnesses, administer oaths, and take acknowledgments while acting in that capacity.

26.1-13-24. Assessments for payment of losses and expenses. When the amount of any loss has been determined, if it appears that the amount of loss exceeds the amount of cash funds of the company applicable to the payment of the loss, the president shall convene the board of directors of the company, and the board must make an

assessment, in an amount at least sufficient to pay the loss, and must apportion the assessment among the members of the company proportionately to the amount of insurance severally carried by them in the company. If a quorum of the members of the board of directors is not present at the meeting, the secretary shall enter that fact and the names of the directors present upon the secretary's journal, and the president, secretary, and treasurer shall proceed to estimate the rate percent of assessment necessary to cover the loss and the expense incurred by the company in connection therewith, and to assess the rate upon all of the insured members of the company. An assessment made by the officers under this section is a valid assessment and must be collected as though it had been made by the board of directors in the regular manner. If an assessment is not collected when due and the amount actually collected is insufficient to pay the losses or expenses of the company, a second assessment must be made, and subsequent assessments must be made from time to time, in the manner provided in this section, upon the policyholders who have paid their previous assessments, until a sufficient amount is collected to pay in full all of the losses and expenses of the company.

26.1-13-25. Permanent expense and loss fund - Assessment or premiums - Delinquent loss assessments credited. The board of directors of a county mutual insurance company may levy and collect an assessment or may charge premiums on its policies for the purpose of providing funds for the payment of the current expenses of the company or for the purpose of establishing a permanent loss fund. The fund may not exceed two percent of the amount of insurance in force in the company, except that where a company writes a combined policy of fire and windstorm insurance, it may maintain a permanent loss fund not to exceed four percent of the amount of insurance in force in the company. Assessments levied for the purposes specified in this section must be collected as assessments made for the payment of current losses are collected. If a delinquent loss assessment is collected after other assessments to cover the loss have been collected, the amount collected on the delinquent loss assessment must be added to the permanent loss fund.

26.1-13-26. Notice of assessment - Extension of time of payment of assessment. The secretary of a county mutual insurance company, whenever any assessment has been completed, shall notify every member of the company by letter sent to the member's last known post-office address, postage prepaid, by a notice stating:

1. The amount of the assessment.
2. The purpose for which the assessment was made.
3. If the assessment was made for the purpose of paying specified losses, the amount of each loss.
4. The sum due from the member as the member's share of the assessment.

5. The time, not less than thirty days nor more than sixty days after the date of the notice, when and the person to whom payment must be made.

The board of directors may grant an extension not exceeding sixty days for the payment of the assessment if in its judgment it is in the best interests of the company to do so.

26.1-13-27. Collection of assessments - Suits against directors - Suits against company to recover losses. Suits may be brought against any member of a county mutual insurance company who neglects or refuses to pay any assessment made upon the member under this chapter. Any director of the company who willfully refuses or neglects to perform the duties imposed upon the director by this chapter is liable in an individual capacity to any person sustaining loss thereby. A civil action may be brought against the company by any member for losses sustained if payment is withheld after losses have become payable.

26.1-13-28. Borrowing of money authorized - Repayment from assessments. The board of directors of a county mutual insurance company, in its discretion, may borrow money for the payment of unpaid losses. Any money borrowed must be repaid from moneys collected from the next ensuing assessment levied in accordance with this chapter.

26.1-13-29. Withdrawal from membership. Any member of a county mutual insurance company may withdraw from membership at any time while the company continues to transact the business for which it was organized if, by withdrawal, the number of members remaining in the company will not be reduced below the original number of incorporators, or the assets of the company will not be reduced below the amount at the time of incorporation. In order to withdraw, a member shall surrender the policy for cancellation; give written notice of withdrawal to the secretary of the company; and pay the member's share of all claims then existing against the company.

26.1-13-30. Cancellation of policies. A county mutual insurance company at any time may terminate or cancel any policy issued by it by giving the insured not less than five days' written notice of the termination or cancellation of the policy and returning to the insured pro rata any unearned premium which the insured may have paid to the company.

26.1-13-31. County mutual fire and lightning companies may form reinsurance company. Any number, not less than five, of county mutual fire and lightning insurance companies organized under this chapter may form a corporation for the purpose of reinsuring the fire, lightning, and extended coverage and other risks of its members permitted to be written under this chapter on the mutual plan.

26.1-13-32. Articles of incorporation and bylaws of mutual reinsurance company - Contents. The articles of incorporation of a reinsurance company organized under section 26.1-13-31 must state:

1. The name of the company, which must include the words "mutual reinsurance company".

2. The purpose for which the company is organized.

3. The location of its principal place of business, which must be within this state.

4. The number of directors of the company, which may not be less than five nor more than thirteen.

5. The names and places of residence of the persons who are to serve as directors of the company until the election and qualification of their successors.

6. The term of its corporate existence, which may be perpetual.

The articles may set forth any other provisions permitted under the provisions of the general law governing profit corporations or permitted in the case of a county mutual insurance company. The bylaws of the company must contain the provisions for its government and the conduct of its business as are permitted in the case of a county mutual insurance company.

26.1-13-33. Articles and bylaws of mutual reinsurance company - Certificate of authority - Right to do business. The articles of incorporation and bylaws of a mutual reinsurance company formed under section 26.1-13-31 must be submitted for approval to the attorney general and to the commissioner. If the articles and bylaws are found to conform with this chapter and not inconsistent with the constitution or laws of this state, the commissioner shall approve the articles and bylaws and they must be filed in the office of the secretary of state. A certified copy of the articles and bylaws then must be filed with the commissioner, and a copy must be delivered to the members of the company. The commissioner shall issue a certificate to the effect that the company has complied with the requirements of law. The certificate is the company's authority to commence business and issue policies. A certified copy of the articles and the certificate may be used for or against the company with the same effect as the originals and is conclusive evidence of the organization of the company as of the date of the certificate.

26.1-13-34. Annual statement to be furnished to members of county mutual company or of mutual reinsurance company. The secretary of each county mutual insurance company and of each mutual reinsurance company formed under this chapter shall prepare and submit to the members of the company, at each annual meeting, a copy of the annual statement required to be filed with the commissioner under section 26.1-03-07.

SECTION 14. Chapter 26.1-14 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-14-01. Purpose. There is a nationwide crisis in the field of medical malpractice insurance and physicians practicing medicine within the state of North Dakota are finding, or will find, it increasingly difficult, if not impossible, to obtain medical malpractice insurance. The purpose of this chapter is to provide for the payment of indemnities to persons suffering injury arising out of the rendering of or the failure to render professional services by physicians and to provide means whereby physicians may obtain insurance against liability therefor, subject to the limitations and immunities provided in this chapter.

26.1-14-02. Definitions. As used in this chapter, unless the context or subject matter otherwise requires:

1. "Company" means the North Dakota medical malpractice mutual insurance company.

2. "Physician" means physician and surgeon (M.D.) and osteopathic physician and surgeon (D.O.).

3. "Practice of medicine" means the practice of medicine, surgery, and obstetrics and has the same meaning specified in subsection 2 of section 43-17-01.

26.1-14-03. Authority. An incorporated mutual insurance company is authorized, to be known as the North Dakota medical malpractice mutual insurance company. The company is subject to and governed by this chapter and is not subject to the laws of this state relating to insurance and insurance companies except as specifically provided in this chapter. The company has all the powers, privileges, and immunities granted by and is subject to all the obligations imposed upon a mutual insurance company under chapter 26.1-12 and the North Dakota Nonprofit Corporation Act. If a provision of chapter 26.1-12 or a provision of the North Dakota Nonprofit Corporation Act and provision of this chapter are both by their terms applicable, the provision of this chapter controls.

26.1-14-04. Board of directors - Articles of incorporation - Bylaws - Insuring powers.

1. The company will be governed by a board of directors consisting of eleven members. The commissioner shall appoint the initial board within thirty days of notification by the state board of medical examiners of its decision for implementation of this chapter from fifteen nominees proposed by that board. The initial board must serve for an initial term of seven months. Thereafter, the directors must be elected by the members of the company in accordance with the articles of incorporation and bylaws.

2. At least seven members of the board of directors must be licensed physicians and at least two members of the board

must have had insurance underwriting or claims handling experience.

3. Within thirty days after appointment by the commissioner, the initial board of directors must prepare and file articles of incorporation and bylaws in accordance with this chapter and chapter 26.1-12.

4. Upon filing the articles of incorporation and bylaws with the commissioner, the articles and bylaws are operative and the commissioner shall issue a certificate of authority subject only to verification by the commissioner that the required initial surplus of the company has been paid and all deposits have been completed.

5. The certificate of authority authorizes the company to issue policies of casualty insurance as follows:

   a. Insurance against liability of physicians for injury arising out of the rendering of or failure to render professional services by the insured.

   b. Insurance against the liability of any person for whose act or omissions a physician is responsible under subdivision a, or with whom the physician is associated, including partners, employees, employers, associates, consultants, or a professional service corporation whose stock is owned by an insured.

   c. Insurance against other liabilities for injury by persons employed in, by property used in, or by activities incidental to, the practice of medicine by the named insured, when issued as incidental coverage with or supplemental to insurance specified in subdivision a.

26.1-14-05. Initial policyholders surplus - Tax - Membership fee.

1. If physicians practicing medicine within North Dakota find it difficult to obtain medical malpractice insurance, the state board of medical examiners, by a majority vote of its membership, may elect to initiate and implement this chapter. Before fifteen days from the date the election to implement this chapter is made, the board must certify to the state treasurer a list of all licensed physicians as shown in the latest record of the board.

2. A special one-time tax for the privilege of practicing medicine in North Dakota will be levied on licensed physicians listed by the state treasurer in accordance with subsection 1 in the amount of five hundred dollars per licensed physician, to be levied, assessed, and collected by the state treasurer. The tax does not apply to any physician who submits a statement, sworn to under

penalties of perjury, stating that the physician has permanently terminated the practice of medicine in the state of North Dakota. The state treasurer shall prescribe the form of the statement.

3. The legislative assembly appropriates and dedicates the entire proceeds of the tax provided by this chapter as the initial policyholders surplus of the company, and the treasurer and director of the office of management and budget shall promptly pay over the proceeds of the tax to the company.

4. The board of directors of the company may establish membership fees in amounts as it deems reasonable to be paid by members of the company. Any physician who has paid the tax specified in subsection 2 must be credited the amount of the tax paid against the liability for any membership fee.

5. Upon payment of the specified membership fee, a physician may be insured by the company for any and all hazards customarily insured by the company, subject to any limitation of coverage specified by the company in accordance with policy limitations, exclusions, conditions, deductibles, and loss sharing requirements.

26.1-14-06. Minimum surplus. The minimum surplus to be maintained by the company shall be three hundred thousand dollars.

26.1-14-07. Management and administration of the company.

1. If, in the judgment of the board of directors, the affairs of the company thereby may be administered suitably and efficiently, the company may enter into a contract, not to exceed five years in duration, whereby the affairs of the company may be administered by a licensed insurer or a licensed nonprofit health service plan, subject to any continuing direction by the board of directors as specified in the articles of incorporation, the bylaws, and the contract.

2. The basis of compensation to the administering licensed insurer or plan in any contract described in this section must be reimbursement of expenses reasonably allocable to the business of the company plus an appropriate and reasonable additional allowance as specified in the contract. Any additional allowance, if based upon premium volume or size of membership, must contain a reasonable aggregate dollar maximum. The amount of the fee may not be made dependent on the underwriting or investment profits of the company.

3. Upon the execution of any contract, the company must promptly file a copy with the commissioner. The contract

becomes effective thirty days from the date of the filing unless the commissioner, prior to the effective date, disapproves the contract as illegal, unduly onerous, or not in the best interest of the company and states the reasons for the findings.

26.1-14-08. Rates and rate filing. The rates and premiums to be charged for insurance by the company are subject to chapter 26.1-25 except that the commissioner may not disapprove or terminate the effectiveness of any rate filing made by or on behalf of the company on the grounds that the rates or premiums are excessive.

26.1-14-09. Reserves for malpractice claims.

1. The reserve maintained by the company for outstanding losses under insurance against injury arising out of the rendering of or the failure to render professional services by an insured for all policies written during the eight years immediately preceding the date of the reserve determination must be seventy percent of the earned premiums of each of the eight years less all losses and loss expense payments made under policies written in the corresponding years.

2. In any event, the reserves for each of the eight years may not be less than the aggregate of estimated unpaid losses and loss expenses for claims incurred under liability policies written in the corresponding year computed on an individual case basis as to cases known and reported, plus reserves in an amount estimated in the aggregate to provide for the payment of all losses or claims incurred on or prior to the date of valuation but not previously reported, including an amount estimated to provide for the expenses of adjustment, settlement, or litigation of the losses or claims.

26.1-14-10. Dividends to policyholders. Every policy issued by the company must include a provision that the company periodically will ascertain and apportion any divisible surplus under the policy which may accrue on policy anniversaries or other dividend dates specified in the contract. This provision must provide that no apportionment or payment of any divisible surplus may take place until the expiration of at least eight years from the termination of the policy period for which the dividend applies. This provision also must provide that the dividends may be paid only as directed by the board of directors from divisible surplus after due consideration of the financial condition and operating needs of the company.

26.1-14-11. Limited liability of insureds.

1. Any person insured by the company for liability because of injury arising out of the rendering of or the failure to render professional services in limits equal to or greater than five hundred thousand dollars for each claim or suit

covered, subject to an aggregate limit of liability for all claims insured in a single policy period equal to or in excess of one million dollars, is immune from all liability in excess of these limits, and further is immune from any liability for sums owing by the company under the terms of the policy regardless of whether or not the company has paid the sums. The immunity established by this section applies to an insured individual or professional service corporations notwithstanding any other provision of the law.

2. This section does not relieve an insured from the insured's personal share of liability not in excess of the five hundred thousand dollar and one million dollar limitations specified in subsection 1 for a loss, expense, or damage not insured by the company by reason of noncoverage, exclusions, deductibles, loss sharing provisions, or conditions in the applicable policy of the company.

26.1-14-12. Terms of coverage - Classifications.

1. The terms and conditions of all policies issued by the company to physicians must be essentially uniform in terms and coverage.

2. Notwithstanding subsection 1, the company may prescribe reasonable classifications of physicians' and insureds' activities and exposures based on good faith determination of relative exposures and hazards among classifications and may vary the limits, coverages, exclusions, conditions, and loss sharing provisions among classifications. Additionally the company may describe in the case of an individual physician within a class, reasonable variations in the terms of coverage including, but not limited to, deductibles in loss sharing provisions, based upon the insured's prior loss experience and current professional training and capability.

26.1-14-13. Exemption from taxation. The property, income, premiums, and activities of the company are exempt from all taxes and assessments and from any fees specified for licenses and certifications of the insurance laws with the exception of any assessment made by the insurance guaranty association in the event that an affirmative election is held in accordance with section 26.1-14-15.

26.1-14-14. Services to the company. Any licensed nonprofit health service plan by appropriate action of the board of directors or board of trustees may enter into a contract with the company in accordance with section 26.1-14-07, for the furnishing of services to the company. In the performance of the services under any contract, the contracting health service plan is subject to the provisions of this chapter applying to the company.

26.1-14-15. Optional membership in insurance guaranty association. The company may not be a member insurer under chapter 26-36 unless the board of directors by appropriate resolution, certified to and filed with the commissioner on or before December thirty-first following the issuance of its certificate of authority, elects to become a member. If there is an affirmative election, the company becomes a member of the insurance guaranty association effective July first of the following year. The election is irrevocable. In absence of a timely election, no policyholder, claimant, or creditor of the company may receive any payment by the insurance guaranty association.

SECTION 15. Chapter 26.1-15 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-15-01. "Fraternal benefit society" defined. A fraternal benefit society is any corporation, society, order, or voluntary association, without capital stock, organized and carried on solely for the mutual benefit of its members and their beneficiaries and not for profit, having a lodge system with a ritualistic form of work and a representative form of government, and making provisions for the payment of death benefits in accordance with section 26.1-15-20.

26.1-15-02. "Lodge system" defined. A lodge system is a system having a supreme governing or legislative body, and subordinate lodges or branches by whatever name known, into which members are elected, initiated, and admitted in accordance with the entity's constitution, laws, rules, regulations, and prescribed ritualistic ceremonies, and which are required by the laws of the entity to hold regular or stated meetings at least once in each month.

26.1-15-03. Representative form of government defined - Proxy prohibited - Supreme meeting in emergency. A fraternal benefit society has a representative form of government when it provides in its constitution and laws for a supreme legislative or governing body composed of representatives elected by the members or delegates elected directly or indirectly by the members, together with any other members as may be prescribed by its constitution and laws if:

1. The elective members constitute a majority in number and have not less than two-thirds of the votes, nor less than the number of votes required to amend the constitution and laws of the society;

2. The meeting of the supreme governing body and the election of officers, representatives, or delegates is held as often as once in four years;

3. The officers are elected either by the supreme legislative or governing body or by the board of directors; and

4. The members, officers, representatives, or delegates of the society do not vote by proxy.

However, during any period of a national emergency, upon petition or application duly made by the executive officer of any society to the commissioner at least sixty days prior to the date on which the supreme or governing body is to meet, the commissioner, in the commissioner's discretion, upon a complete investigation of the merits of the petition or application, may grant a continuance or postponement of the meeting for a period of not to exceed one year. If the emergency continues to exist at the end of the postponement period, a further petition or application may be made and a further continuance or postponement may be granted. No continuance may be granted after the period of the emergency ceases to exist.

26.1-15-04. Exception from application of general insurance laws. Except as otherwise provided in this chapter, a fraternal benefit society is governed by this chapter and is excepted from all other provisions of the insurance laws of this state, unless the society is expressly designated in the law.

26.1-15-05. Organization of society - Minimum number of organizers. Any number of persons, not less than seven, all of whom are citizens of the United States of America and a majority of whom are bona fide citizens of this state, may form a fraternal benefit society by complying with this chapter.

26.1-15-06. Articles of incorporation - Execution - Contents. Persons proposing to form a fraternal benefit society shall make, sign, and acknowledge before an officer competent to take acknowledgments of deeds, articles of incorporation specifying:

1. The addresses of the persons proposing to form the society.

2. The proposed corporate name of the society, which may not so closely resemble the name of any other society or insurance company already transacting business in this state as to mislead the public or lead to confusion.

3. The purpose for which the society is to be formed, which may include any lawful social, intellectual, educational, charitable, benevolent, moral, or religious advantages to be furthered by the society, but may not involve the use of more liberal powers than are granted by this chapter, and the mode in which its corporate powers are to be exercised.

4. The names, residences, and official titles of all of the officers, trustees, directors, or other persons who are to have and exercise the general control and management of the affairs and funds of the society for the first year, or until the ensuing election at which all the officers must be elected by the supreme legislative or governing body of the society, and the election must be held within one year after the date upon which a permanent certificate is issued to the society.

26.1-15-07. General powers of domestic society. A domestic fraternal benefit society may make a constitution and laws for the government of the society, the admission of members, the management of its affairs, and for the fixing and readjusting of the rates of contribution of its members. It may amend or add to its constitution and laws any other powers necessary and incidental to carrying into effect the objects and purposes of the society.

26.1-15-08. Laws of society - Increased contributions. The laws of each domestic fraternal benefit society must provide that if the stated periodical contributions of the members are insufficient to pay all matured death and disability claims in full and to provide for the creation and maintenance of the funds required by its laws, additional, increased, or extra rates of contribution are to be collected from the members to meet the deficiency. The laws may provide that, upon the member's written application or consent, the member's certificate may be charged with its proportion of any deficiency disclosed by valuation, with interest not exceeding five percent per annum.

26.1-15-09. Waiver of constitution and laws. The constitution and laws of a fraternal benefit society may provide that no subordinate body, nor any of its subordinate officers or members, may waive any of the provisions of the constitution and laws of the society, and the nonwaiver provisions are binding on the society, every member, and on all beneficiaries of members.

26.1-15-10. Place of meeting - Location of office. A domestic fraternal benefit society may provide that the meetings of its legislative or governing body may be held in any state, district, or province in which the society has subordinate branches, and all business transacted at the meetings is as valid as if the meetings were held in this state. Its principal office, however, must be located in this state.

26.1-15-11. Articles and other instruments and forms - Filing - Bond - Preliminary certificate. Persons proposing to form a fraternal benefit society shall file with the commissioner:

1. The articles of incorporation of the proposed society.
2. Certified copies of its constitution, laws, rules, and regulations.
3. Copies of all proposed forms of benefit certificates, applications for certificates, and circulars to be issued by the society.
4. A bond in the sum of five thousand dollars, with sureties to be approved by the commissioner, conditioned for the return of all advance payments to applicants as provided in this chapter if the organization of the society is not completed within one year after the issuance of the preliminary certificate.

5. Any further information the commissioner requires.

The articles of incorporation must be submitted by the commissioner to the attorney general for approval. The commissioner shall approve the articles of incorporation, if the purposes of the society conform to the requirements of this chapter and there is compliance with all applicable provisions of law. The approved articles must be filed in the office of the secretary of state and a certified copy must be filed with the commissioner. Thereupon the commissioner shall issue to the incorporators a preliminary certificate stating that the applicable provisions of law have been complied with and authorizing the society to solicit members as provided in this chapter. The preliminary certificate is valid for one year from its date or for any further period, not exceeding one year, authorized by the commissioner upon cause shown. The articles of incorporation and all proceedings thereunder become void at the expiration of one year from the date of the certificate, or at the expiration of the extended period, unless the society has completed its organization and commenced business as provided in this chapter.

26.1-15-12. Powers of society upon issuance of preliminary certificate - Solicitation of members - Restrictions. Upon receipt of a preliminary certificate, a fraternal benefit society may solicit members for the purpose of completing its organization. It must collect from each applicant for membership the amount of not less than one regular monthly payment in accordance with the table of rates prescribed by its constitution and laws, and must issue to each applicant a receipt for the amount collected. However, a society may not:

1. Incur any liability other than for advance payments made by applicants for membership;

2. Issue any benefit certificate; or

3. Pay or allow, or offer or promise to pay or allow, to any person any death or disability benefit until:

   a. Actual bona fide applications for death benefit certificates have been secured upon at least five hundred lives for at least one thousand dollars each;

   b. All of the applicants have been examined regularly by legally qualified practicing physicians and certificates of examinations have been filed and approved by the chief medical examiner of the society;

   c. There has been established at least ten subordinate lodges or branches into which the five hundred applicants for membership have been initiated;

   d. There has been submitted to the commissioner, under oath by the president and secretary, or corresponding officers, of the society, a list of the applicants for membership giving their names and addresses, the dates

upon which they were examined, the date of approval of the examinations, the name and number of the subordinate lodge or branch of which each applicant is a member, the amount of benefits to be granted by the society, the society's rate of stated periodical contributions which must be sufficient to provide for meeting the mortuary obligations contracted when valued for death benefits upon the basis of the National Fraternal Congress Table of Mortality and four percent interest or any higher standard at the option of the society, or any mortality tables and interest assumptions now or hereafter authorized for use by life insurance companies, and the society's rate of stated periodical contributions for disability benefits by tables based upon reliable experience with an interest assumption not higher than four percent per annum; and

e. It has been shown to the commissioner by the sworn statement of the treasurer or corresponding officer of the society that at least five hundred applicants have paid in cash at least one regular monthly payment as provided in this section for each one thousand dollars of indemnity to be effected. The payments, in the aggregate, must amount to at least two thousand five hundred dollars. The payments, during the period of organization, must be held in trust and credited to the mortuary or disability funds on account of the applicants, and may not be used for expenses. If the organization of the society is not completed within one year as provided in this chapter, the payments must be returned to the applicants.

26.1-15-13. Issuance of certificate of authority - Certified copy as evidence. After the fraternal benefit society has complied with the requirements specified in section 26.1-15-12, the commissioner may make the examination and require any further information the commissioner deems advisable, and, upon presentation to the commissioner of satisfactory evidence that the society has complied with all of the provisions of applicable law, the commissioner shall issue to the society a certificate to that effect. The certificate is prima facie evidence of the existence of the society on the date of the certificate and of the society's authority to do business in this state. The commissioner must make a record of the certificate, and a certified copy of the record may be given in evidence as if it were the original certificate.

26.1-15-14. Certificate of authority - Expiration - Annual license and fee. The certificate of authority to transact business within this state issued to a fraternal benefit society expires on April thirtieth following the date of issuance and must be renewed annually. The fee for issuing the certificate or license, and for each renewal thereof, is that specified in section 26.1-01-07.

26.1-15-15. Foreign society - Admission to transact business - Qualifications - Annual fee. A foreign fraternal benefit society may not transact business in this state unless it is authorized and licensed to do so by the commissioner. A foreign society may not be licensed to do business in this state unless it possesses the qualifications required of domestic societies organized under this chapter nor unless it has its assets invested as required by the laws of the state, district, country, or province in which it is organized. A foreign society which complies with the foregoing provisions is entitled to a license to transact business in this state upon filing with the commissioner:

1. A duly certified copy of its charter or articles of incorporation.

2. A copy of its constitution and laws certified by its secretary or corresponding officer.

3. A power of attorney to the commissioner as provided in section 26.1-15-16.

4. A statement, under the oath of its president and secretary or corresponding officers, in the form required by the commissioner showing the business of the society, and duly verified by an examination made by the supervising insurance official of its home state or of some other state satisfactory to the commissioner.

5. A certificate from the proper official of its home state, province, or country showing that the society is organized legally.

6. A copy of its contract which must show that benefits are provided for by periodical or other payments by persons holding similar contracts.

7. Any other information the commissioner deems necessary to a proper exhibit of its business and plan of working.

26.1-15-16. Foreign society - Power of attorney and consent to service of process. Before being licensed to do business in this state, every foreign fraternal benefit society must, in writing, appoint the commissioner and the commissioner's successors in office to be its true and lawful attorney upon whom all legal process in any action or proceeding against it must be served, and in the writing it must agree that any lawful process against it which is served upon the attorney is of the same legal force and validity as if it were served upon the society and that the authority of the attorney to accept service for it continues in force so long as any liability of the society remains outstanding in this state.

26.1-15-17. Refusal to license foreign society and revocation of authority - Procedure - Review. Whenever the commissioner refuses to license any foreign fraternal benefit society, or revokes its authority to

do business in this state, the commissioner shall reduce the ruling, order, or decision to writing and shall file it in the commissioner's office. The commissioner shall furnish a copy, together with a written statement of the reasons for the decision, to the officers of the society upon request.

26.1-15-18. Amendments to constitution and laws - Filing with commissioner - Effect. Every fraternal benefit society transacting business under this chapter must file with the commissioner a duly certified copy of all amendments to its constitution and laws within ninety days after enactment. Printed copies of the constitution and laws as amended, certified by the secretary or corresponding officer of the society, are prima facie evidence of legal adoption.

26.1-15-19. License or certificate - Renewal or refusal. A certificate of authority or license issued to a domestic or foreign fraternal benefit society continues in full force and effect until a new certificate or license is issued or refused specifically.

26.1-15-20. Benefits generally - Required and optional. Every fraternal benefit society transacting business under this chapter must provide for the payment of death benefits to its members and may provide for:

1. The payment of benefits in case of temporary or permanent physical disability as the result of disease, accident, or old age, but the period of life at which the payment of benefits or disability on account of old age commences may not be under seventy years.

2. Monuments or tombstones to the memory of its deceased members.

3. The payment of funeral benefits.

4. Giving to a member, when the member is disabled permanently or has attained the age of seventy years, the face value of the member's certificate or any portion of the face value as the laws of the society provide.

5. Issuing a benefit certificate for a term of years less than the life of the member payable upon the death or disability of the member occurring within the term for which the benefit certificate is issued.

6. If it shall show by the annual valuation provided for in this chapter that it is accumulating and maintaining a reserve not lower than the usual reserve computed by the American Experience Table and four percent interest, or any mortality tables and interest assumptions now or hereafter authorized for use by life insurance companies, issuance of endowment certificates, and the granting to its members extended and paid-up protection or such withdrawal equities, as its constitution and laws may

provide. The grants, however, may not exceed in value the portion of the reserves to the credit of the members to whom the grants are made.

26.1-15-21. Society may provide family protection. Any fraternal benefit society authorized to do business in this state may provide in its laws, in addition to other benefits, for insurance and annuities, or for insurance or annuities, upon the lives of children at any age, to be issued upon the application of an adult person as the laws of the society may provide, subject to the following:

1. The society, at its option, may organize and operate branches for the children, and membership in local lodges, and initiation therein, may not be required of the children nor may they have any voice in the management of the affairs of the society.

2. The contributions to be made upon certificates issued under this section must be based upon the Standard Industrial Mortality Table and three and one-half percent, or upon the English Life Table Number Six, or upon any mortality tables and interest assumptions now or hereafter authorized for use by life insurance companies.

3. The society must maintain on all the certificates the reserve required by the standard of mortality and interest adopted by the society for computing contributions as provided in subsection 2.

4. The society may provide for the regulation, government, and control of certificates issued pursuant to this section and of all rights, obligations, and liabilities incident thereto, including the means of enforcing payment of contributions, designation of beneficiaries, and the changing of the designations, but not at variance with this chapter.

26.1-15-22. Funds of society - Emergency - Surplus - Derivation - Use - Contributions. Any fraternal benefit society may create, maintain, invest, and disburse, an emergency, surplus, or other similar fund in accordance with its laws. Unless otherwise provided in the contract of the society, the funds must be held, invested, and disbursed for the use and benefit of the society, and no member or beneficiary may have or acquire individual rights therein or become entitled to any apportionment or to the surrender of any part thereof, except as provided in subsection 6 of section 26.1-15-20. The funds from which benefits are paid, and the funds from which the expenses of the society are defrayed, must be derived from periodical or other payments by the members of the society and accretions to those funds. A domestic society may not be incorporated, and a foreign society may not be admitted to transact business in this state unless it requires stated periodical contributions sufficient to provide for meeting the mortuary obligations contracted by the society when they are valued upon the

basis of the National Fraternal Congress Table of Mortality, or upon the basis of any higher standard, with interest assumption at not more than four percent per annum, or upon any mortality tables and interest assumptions now or hereafter authorized for use by life insurance companies, and a society may not write or accept members for temporary or permanent disability benefits within this state except upon tables based upon reliable experience, with an interest assumption not higher than four percent per annum.

26.1-15-23. Deferred payments or installments of claims - Fund for fixed liabilities. Deferred payments or installments of claims are fixed liabilities on the happening of the contingency following which the payments or installments are to be paid. The liability is the present value of the future payments or installments upon the rate of interest and mortality assumed by the society for valuation. Every society must maintain a fund sufficient to meet the liabilities regardless of proposed future collections to meet any of the liabilities.

26.1-15-24. Investment of funds. A fraternal benefit society may invest its funds only in securities permitted by the laws of this state for the investment of the assets of life insurance companies. Any foreign society permitted or seeking to do business in this state, however, which invests its funds in accordance with the laws of the state in which it is incorporated meets the requirements of this chapter relating to the investment of funds.

26.1-15-25. Use of funds - Restrictions - Purposes. A fraternal benefit society, the admitted assets of which are less than the sum of the required reserves and accrued liabilities, must, in every provision of the laws of the society for payments by members of the society, in whatever form made, distinctly state the purpose of the payments and the proportion thereof which may be used for expenses, and the money collected for mortuary or disability purposes or the net accretions thereto may not be used for expenses.

26.1-15-26. Solicitation of membership in unlicensed society. A person may not solicit membership in, or in any manner assist in procuring membership for, a fraternal benefit society which is not licensed to do business in this state under this chapter.

26.1-15-27. Qualifications for membership. A fraternal benefit society may admit to beneficial membership any person not less than fifteen years of age at the nearest birthday who has been examined by a legally qualified physician and whose examination has been supervised and approved in accordance with the laws of the society, or who has made declaration of insurability acceptable to the society. A member who applies for additional benefits more than six months after becoming a beneficial member shall pass an additional medical examination, or make an additional declaration of insurability, as required by the society.

Any person admitted prior to attaining the age of eighteen years is bound by the terms of the application and certificate and

by all the laws and rules of the society, and is entitled to all the rights and privileges of membership, to the same extent as though the age of majority had been attained at the time of application. A society also may accept general or social members who shall have no voice or vote in the management of its insurance affairs.

26.1-15-28. Certificate of membership and beneficiary - Contents - Evidence. A certificate issued by a fraternal benefit society must specify the amount of benefit provided thereby, and must provide that the certificate, the charter or articles of incorporation, and the laws of the society, and all amendments to any of them, and the application for membership and medical examination signed by the applicant, constitutes the agreement between the society and the member. A copy of the certificate certified by the secretary or corresponding officer of the society is evidence of the terms and conditions thereof. Any amendments to the charter or articles of incorporation, constitution, or laws, duly made or enacted subsequent to the issuance of the benefit certificate, binds the member and the member's beneficiaries and governs and controls the agreement the same as though the amendments had been made prior to and were in force at the time of the application for membership.

26.1-15-29. Contributions charged against certificate - Limitation. A fraternal benefit society which makes periodical assessments adequate in amount to permit the establishment of a reserve for certificates issued by it may accept a part of the periodical contribution in cash upon the written application of the member involved and may charge against the certificate the remainder of the contribution, which may not exceed one-half of the contribution, with interest payable or compounded annually at a rate not lower than four percent per annum. A society may take advantage of this section only in connection with contracts upon which the periodical contributions are sufficient to establish a reserve as specified herein.

26.1-15-30. Beneficiaries - Funeral benefits. A member has the right at any time to change the beneficiary or beneficiaries in accordance with the constitution, laws, or rules of the fraternal benefit society. A society by its constitution, laws, or rules may limit the scope of beneficiaries and may provide that no beneficiary may have or obtain any vested interest in the proceeds of any certificate until the certificate has become due and payable in conformity with the insurance contract.

A society may provide for the payment of benefits not exceeding the sum of three hundred dollars as funeral benefits to any person as may reasonably appear to the society to be equitably entitled thereto by reason of having incurred expense occasioned by the burial of the member.

26.1-15-31. Personal liability of officers and members of society. Officers and members of the supreme or grand, or of any subordinate, body of a fraternal benefit society which has complied with this chapter are not liable individually for the payment of any benefit

provided for in the laws and agreements of the society, and any benefit is payable only out of the funds of the society and in the manner provided by its laws.

26.1-15-32. Benefits exempt from process. No money or other benefit, charity, relief, or aid to be paid, provided, or rendered by a fraternal benefit society is liable to attachment, garnishment, or other process, or to seizure, taking, appropriation, or application by any legal or equitable process, or by operation of law, to the payment of any debt or liability of a member or beneficiary, or of any other person who may have a right thereunder, either before or after payment.

26.1-15-33. Merger or transfer by domestic society. A domestic fraternal benefit society may not merge with, or accept the transfer of the membership or funds of, any other society unless the merger or transfer is evidenced by a written contract setting out in full the terms and conditions of the merger or transfer and the contract is filed with the commissioner, together with a sworn statement of the financial condition of each contracting society made by the respective presidents and secretaries, or corresponding officers. In addition, a verified certificate by the officers of each contracting society, that the merger or transfer has been approved by a vote of two-thirds of the members of the supreme legislative or governing body of the society must be filed with the commissioner. After the contract, financial statements, and certificates are filed, the commissioner must examine them, and if the commissioner finds that the financial statements are correct, that the contract is in conformity with this section, and that the merger or transfer is just and equitable to the members of each society, the commissioner shall approve the merger or transfer and issue a certificate to that effect. Thereafter, the contract of merger or transfer is in full force and effect. In case the contract is not approved, the fact of its submission and its contents may not be disclosed by the commissioner.

26.1-15-34. Charter of domestic society nullified by nonuser or depletion in membership. When any domestic fraternal benefit society has discontinued business for the period of one year, or has less than four hundred members, its charter is void.

26.1-15-35. Annual report - Additional reports. A fraternal benefit society transacting business in this state, before March second of each year, must file with the commissioner, in the form the commissioner requires, a statement, under the oath of its president and secretary or corresponding officers, showing its condition and standing as of the preceding December thirty-first and its transactions for the year ending upon that date. It must furnish any other information the commissioner deems necessary to a proper understanding of its business and plan of working. The commissioner, at other times, may require any further statement relating to the society and its affairs which the commissioner deems necessary.

26.1-15-36. Report of certificate valuation - Verification - Minimum standard of valuation. Annually, and within ninety days after the submission of the last preceding annual report, a fraternal benefit society transacting business in this state must file with the commissioner a report showing the valuation of its certificates in force on the preceding December thirty-first, and including those issued within the year for which the report is filed in cases where the contributions for the first year are used in whole or in part for current mortality and expense payments. The valuation must be certified by a competent accountant or actuary, or, at the request and expense of the society, verified by the actuary of the department of insurance of the home state or province of the society. The legal minimum standard of valuation for all certificates, except for disability benefits, is the National Fraternal Congress Table of Mortality and four percent interest, or, at the option of the society any higher table or a table based upon the society's own experience of at least twenty years and covering not less than one hundred thousand lives, with interest assumption of not more than four percent per annum, or any mortality tables and interest assumptions now or hereafter authorized for use by life insurance companies, or any table and interest rate producing greater aggregate net values, such as the Commissioners 1941 Standard Ordinary Table. Each valuation report must set forth clearly and fully the mortality and interest basis and the method of valuation. A society providing for disability benefits must keep the net contributions for these benefits in a fund separate and apart from all other benefit and expense funds and the valuation of all other business of the society. Where a combined contribution table is used by a society for both death and permanent total disability benefits, however, the valuation must be according to tables of reliable experience and in this case, a separation of the funds is not required.

26.1-15-37. Valuation report - Financial solvency. The valuation provided for in section 26.1-15-36 is not to be considered or regarded as a test of the financial solvency of the fraternal benefit society, but the society is held to be solvent legally so long as the funds in its possession are equal to, or in excess of, its matured liabilities.

26.1-15-38. Valuation report distribution and publication. A report of the certificate valuations of a fraternal benefit society, and an explanation of the facts concerning the condition of the society disclosed in the report, must be printed and mailed to each beneficial member of the society not later than June first of each year. In lieu of the printing and mailing, the report and explanation may be published in an issue of the society's official paper if the issue is mailed to each beneficial member of the society.

26.1-15-39. Alternative methods of certificate valuations - Accumulation basis - Tabular basis. A fraternal benefit society which accepts in its laws this section may value its certificates, in lieu of the manner or manners provided in section 26.1-15-36, on the

accumulation basis or on the tabular basis, subject to the following provisions:

1. The accumulation basis must consist in crediting each member with the net amount contributed for each year with interest at approximately the net rate earned, and by charging the member with the member's share of the losses for each year, herein designated as the cost of insurance, and carrying the balance, if any, to the member's credit. In valuing upon this basis:

   a. The charge for the cost of insurance may be according to the actual experience of the society applied to a table of mortality recognized by the laws of this state, and must take into consideration the amount at risk during each year, which is the amount payable at death less the credit to the member.

   b. Except as otherwise specifically provided in the articles, laws, or contracts of the society, a charge may not be carried forward against a member from the first valuation of a society for any past share of losses exceeding the member's contributions and credits.

   c. If, after the first valuation of the society, a member's share of losses for any year exceeds the member's credit, including the contribution for the year, the contribution shall be increased to cover the member's share of the losses.

   d. Any excess share of losses mentioned in subdivisions b and c which are chargeable to any member may be paid out of a fund or from contributions specially created or required for such purpose.

   e. A member may transfer to any plan adopted by the society with net rates on which tabular reserves are maintained and on the transfer, is entitled to make the application of the member's credit as is provided in the laws of the society.

2. If, on the first valuation of a society, a deficiency in reserve is shown for any certificate, the certificates must be valued on the accumulation basis. Otherwise, certificates issued, rerated, or readjusted on a basis providing for an adequate rate with adequate reserves to mature the certificates upon assumption for mortality and interest recognized by the law of this state must be valued on the tabular basis.

3. In a society having members upon the accumulation basis and upon the tabular basis, whenever the total of all costs of insurance provided for any year is insufficient

to meet the actual death and disability losses for the year, the deficiency must be met for the year from:

a. The available funds of the society after setting aside all credits in the reserve;

b. Increased contributions; or

c. Moneys raised by an increase in the number of assessments applied to the society as a whole or to any classes of members specified in its laws.

4. Savings from a lower amount of death losses may be returned in any manner specified in the laws of the society.

5. If the laws of the society so provide, the assets representing the reserves of any separate class of members may be carried separately for the class as if the class were an independent society, and in this case, the required reserve accumulation of a class so set apart may not be mingled thereafter with the assets of any other class of the society.

6. This section does not prevent the maintenance of any surplus over and above the credits on the accumulation basis and the reserves on the tabular basis as may be provided for in the laws of the society.

7. This section does not give to the individual member any right or claim to any reserve or credit mentioned other than in the manner which is expressed in the contract and in the laws of the society.

8. This section does not make any reserve or credit mentioned a liability of the society in determining the legal solvency thereof.

26.1-15-40. Report when valuation on accumulation and tabular basis. A fraternal benefit society which has conformed to section 26.1-15-39 must file with each annual report and statement made by it to the commissioner, and must furnish to each member of the society before June first of each year, a table showing the credits to the individual members for each age and year of entry and showing opposite each credit the tabular reserve required on the whole life or other plan of insurance specified in the contract according to assumptions for mortality and interest recognized by the laws of this state and adopted by the society. Each member of the society may be furnished, in lieu of the statement, before June second of each year, with a statement giving the credit for the member and the tabular reserve and level rate required for a transfer carrying out the plan of insurance specified in the contract. No table or statement, however, need be furnished to the members where the reserves are maintained on the tabular basis. For the purposes

specified in this section and in section 26.1-15-39, individual bookkeeping accounts for each member are not required, and all calculations may be made by actuarial methods.

26.1-15-41. Examination of domestic society - Proceedings to wind up affairs - Notice. An examination of each domestic fraternal benefit society must be made at least once in three years. The commissioner may visit and examine each society. The commissioner shall report the facts to the attorney general, who, if the attorney general deems that circumstances warrant the same, shall commence appropriate action against the society, whenever the commissioner, after examination, is satisfied that the society:

1. Has failed to comply with this chapter;

2. Is exceeding its powers;

3. Is not carrying out its contracts in good faith;

4. Is transacting its business fraudulently;

5. Has a membership of less than four hundred; or

6. Has determined to discontinue business.

Upon the institution of the action, the court must notify the officers of the society of the time and place of the hearing. If it appears at the hearing that the society should be closed, the society must be enjoined from carrying on further business, and some person shall be appointed as receiver of the society. The receiver shall proceed to take possession at once of the books, papers, moneys, and other assets of the society, and forthwith, under the direction of the court, shall proceed to close the affairs of the society and to distribute its funds to those who are entitled to the funds. The attorney general, however, may not commence proceedings under this section until after notice has been served on the chief executive officer of the society and a reasonable opportunity has been given to the society, on a date designated in the notice, to show cause why the proceedings should not be commenced.

26.1-15-42. Application for receiver for domestic society. An application for injunction against or proceedings for the dissolution of, or the appointment of a receiver for, a domestic fraternal benefit society, or branch thereof, may not be entertained by any court in this state unless made or instituted by the attorney general.

26.1-15-43. Examination of foreign society - Revocation of license - Notice. The commissioner may cause any foreign fraternal benefit society transacting, or applying for admission to transact, business in this state to be examined, or instead may accept the examination of the society by the insurance department of the state, district, province, or country in which the society is organized. The commissioner, if the commissioner is satisfied on investigation and

examination that the society has exceeded its powers, has failed to comply with this chapter, is conducting its business fraudulently, or is not carrying out its contracts in good faith, shall notify the society of the findings, stating in writing the grounds of dissatisfaction, and shall require the society, after reasonable notice and on a date and at a place named, to show cause why its license should not be revoked. If the objections have not been removed by the society to the satisfaction of the commissioner on or before the date designated in the notice, or if the society does not present good and sufficient reasons why its authority to transact business in this state should not be revoked at that time, the commissioner may revoke the authority.

26.1-15-44. Refusal of foreign society to submit to examination - License suspended or canceled. If any foreign fraternal benefit society, or its officers, refuse to submit to examination, or to comply with any provision of this chapter relative thereto, the authority of the society to write new business in this state is suspended or a license refused until satisfactory evidence is furnished to the commissioner relating to the condition and affairs of the society, and during suspension, the society may not write new business in this state.

26.1-15-45. Examination of societies - General provisions. The commissioner may employ assistants in the making of any examination provided for in this chapter, and the commissioner, or any person the commissioner appoints, has free access to all the books, papers, and documents of the society being examined which relate to the business of the society, and may summon as witnesses, administer oaths to, and examine under oath, the officers, agents, and employees of the society, and other persons, in relation to the affairs, transactions, and condition of the society. The society must pay the expenses of the examination upon receiving an expense statement furnished by the commissioner.

26.1-15-46. Restrictions on making results of examination public. Pending, during, or after an examination or investigation of a domestic or foreign fraternal benefit society, the commissioner may not make or permit to become public any financial statement, report, or finding affecting the status, standing, or rights of the society until a copy has been served upon the society at its home office and the society given a reasonable opportunity to answer, and to make any showing in connection therewith it may desire.

26.1-15-47. Society exempt from taxation - Exceptions. A fraternal benefit society organized or licensed under this chapter is declared to be a charitable and benevolent institution, and all of its funds are exempt from all state, county, district, and municipal taxes, other than taxes on real estate and office equipment.

26.1-15-48. Society providing only accident protection - Partial exception from chapter. A fraternal benefit society organized and incorporated prior to July 1, 1913, within the definitions set forth in sections 26.1-15-01, 26.1-15-02, and 26.1-15-03, which provides for benefits

in case of death or disability resulting solely from accidents but which does not obligate itself to pay death or sickness benefits, may be licensed under this chapter. If licensed under this chapter, the society has all the privileges and is subject to all the provisions and requirements contained in this chapter, except that the provisions requiring valuation of benefit certificates and specification in the certificates of the amount of benefits do not apply.

26.1-15-49. Societies excepted from chapter. This chapter does not affect or apply to:

1. Grand or subordinate lodges of masons, odd fellows, or knights of pythias, with the exception of the insurance department of the supreme lodge, knights of pythias.

2. The junior order of the united American mechanics, with the exception of the beneficiary degree of the insurance branch of the national council, junior order, united American mechanics.

3. Societies which admit to membership only persons engaged in one or more hazardous occupations in the same or similar lines of business.

4. Societies similar to those mentioned in subsection 3 which do not issue insurance certificates.

5. An association of local lodges doing business in this state on July 1, 1931, which provides death benefits not exceeding five hundred dollars to any one person or disability benefits not exceeding the sum of three hundred dollars in any one year to any one person, or both of these death and disability benefits.

6. Contracts of reinsurance business written in this state on the plan outlined in subsection 5.

7. Domestic societies which limit their memberships to the employees of a particular municipality, designated firm, business house, or corporation.

8. Domestic lodges, orders, or associations of a purely religious, charitable, and benevolent description which do not provide for a death benefit of more than one hundred dollars, or for disability benefits of more than one hundred fifty dollars to any one person in any one year.

The commissioner may require from a society any information to enable the commissioner to determine whether or not the society comes within an exception provided by this section.

26.1-15-50. Failure to conform to chapter - Penalty. A fraternal benefit society, or any officer, agent, or employee of a society,

who neglects or refuses to comply with, or who violates, this chapter, if the penalty for the neglect, refusal, or violation is not specified otherwise, is guilty of an infraction.

SECTION 16. Chapter 26.1-16 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-16-01. "Benevolent society" defined. A benevolent society is a domestic corporation, association, or society which operates on the voluntary assessment or contribution plan for the sole purpose of providing, through assessments of its members, for the payment of a death benefit to the beneficiary of a deceased member.

26.1-16-02. Chapter not applicable to fraternal benefit society. This chapter does not apply to a fraternal benefit society as defined in chapter 26.1-15 nor to a benefit society organized within and limited to members of a fraternal benefit society.

26.1-16-03. Jurisdiction of commissioner. A benevolent society is under the jurisdiction of the commissioner and is subject to all the laws and rules applicable to insurance companies transacting business within this state, except as specifically provided.

26.1-16-04. Organization of society - Minimum number of members. Any number of persons, not less than five, all of whom are residents of this state, may form a benevolent society by complying with the applicable provisions of this chapter.

26.1-16-05. Articles of incorporation - Contents. Persons proposing to form a benevolent society under this chapter shall subscribe and acknowledge articles of incorporation specifying:

1. The name of the society, which must include the words "benevolent society".
2. The purpose for which the society is to be formed.
3. A full and clear definition of the plan under which the society proposes to do business.
4. The time and place of holding meetings of the members of the society.
5. The location of the society's principal office, which must be within this state.
6. The date for the commencement and for the termination of the fiscal year of the society.
7. The term for which the society is to be incorporated, which term may not exceed thirty years.
8. The number of directors, not less than five nor more than nine, all of whom must be residents of this state.

9. The names and addresses of the directors selected to serve until the first meeting of the members of the society.

26.1-16-06. Society doing business on July 1, 1937, need not change name - Requirements. Any benevolent society organized and doing business on July 1, 1937, which has a name which does not include the words "benevolent society" is not required to change its name to comply with section 26.1-16-05, but its membership certificate, stationery, and literature must state clearly that it is a benevolent society.

26.1-16-07. Articles of incorporation - Filing - Approval - Deposit required - Authority to solicit. The articles of incorporation must be submitted to the attorney general, and if the attorney general finds them in conformity with this chapter and not inconsistent with the constitution and laws of this state, the attorney general shall approve the articles and certify them to the commissioner, who also shall examine the articles to ascertain whether they comply with all applicable requirements of the law. After the articles have been approved by the attorney general and by the commissioner, they must be filed in the office of the secretary of state, and a certified copy must be filed with the commissioner. The society must deposit with the commissioner United States government bonds, United States treasury certificates, bonds of the state of North Dakota, or certificates of deposit of the Bank of North Dakota in the amount of at least two hundred fifty dollars. Upon filing the certified copy of its articles and making the deposit, the society may solicit and secure the necessary preliminary members as the basis for the issuance to it of a certificate of authority. The solicitation of such members, however, must be conducted in accordance with any applicable rules adopted by the commissioner.

26.1-16-08. Deposit maintained by society. Before the commissioner may issue a certificate of authority to a benevolent society, the commissioner shall ascertain that the deposit required by section 26.1-16-07 has been made. The society must maintain the deposit until the membership of the society reaches one thousand. Thereafter, the deposit maintained with the commissioner must be equal in amount to at least twenty-five cents per member in good standing.

26.1-16-09. Bylaws required. Each benevolent society must adopt bylaws which conform to its articles of incorporation or to this chapter.

26.1-16-10. Amendment of articles and adoption, amendment, and repeal of bylaws. The articles of incorporation of a benevolent society may be amended, and its bylaws adopted, amended, or repealed, at any annual meeting or at any special meeting called for that purpose. A two-thirds affirmative vote of the members of the society is required to take any of the actions specified in this section.

26.1-16-11. Bonds of officers and agents. After a benevolent society has been licensed by the commissioner, the bonding of its

officers and agents is discretionary with its board of directors. During the period between the filing of articles of incorporation and the issuing of a certificate of authority, however, the commissioner shall set the amounts of the bonds sufficient to guarantee return of membership fees collected in case the organization is not completed, and the bonds must be filed with the commissioner.

26.1-16-12. Territorial restrictions on society - Voluntary contribution plan benefits regulated by chapter. Any society organized under this chapter must confine its activities, insofar as solicitation by agents is concerned, to this state. No benefits on the voluntary contribution plan may be provided by any society except as provided in this chapter.

26.1-16-13. Licensing of agents - Residence requirements. All agents of a benevolent society must be residents of this state and must be licensed in the same manner as agents for insurance companies generally are licensed.

26.1-16-14. Classification of membership - Units. A benevolent society may provide for the classification of its membership by one or more units based on the age of individual members, or by the adoption of a maximum limit of one group or unit. Before the organization of a new group or unit, the society must notify the commissioner of its proposal to organize the group or unit, and the organization must be conducted in accordance with any applicable rules adopted by the commissioner. The number of members in a unit may not be less than is required for the organization of a society. If the membership of any group or unit of any society falls below two hundred, the group or unit must be consolidated with another group or unit of the society unless within sixty days the group or unit has restored its membership to the minimum required by this section. An age group composed of members over age sixty-five, however, may be established and maintained at not less than one hundred members.

26.1-16-15. Preliminary applications required before issuance of certificate of authority - Bank certificate - Issuance of certificate of authority. Before a benevolent society may issue a certificate of membership, it must have actual applications for certificates from at least three hundred persons upon which certificates may be issued simultaneously. The applications, together with a certificate from a solvent bank stating that there has been deposited to the account of the society an amount which is determined by the preliminary applications presented as constituting the entire proceeds of membership fees collected, must be submitted to the commissioner. Upon submission to the commissioner of the preliminary applications, the bank certificate, and any evidence of compliance with this chapter which the commissioner requires, the commissioner may issue to the society a certificate of authority to expire on the thirtieth day of April following the date thereof.

26.1-16-16. Application for and certificate of membership - Contents - Approval - Maximum benefits - Expense deductions. The certificate of membership issued by a benevolent society must state fully the conditions on which the benefit is paid. The certificate of membership and the application for the certificate constitute the entire contract between the society and the member. Every certificate and application must have printed or stamped thereon in red ink and in ten-point boldfaced type "This is not an insurance policy. The society maintains no reserve. All benefits are dependent upon voluntary assessments from members." The commissioner of insurance shall approve the form of the certificate and application prior to their issuance or use. The benefits under any certificate must be confined to a death benefit to the beneficiary of the deceased member in an amount not to exceed two thousand dollars, and the certificate must provide for an assessment on the membership in an amount not exceeding four dollars to be paid by the members after notice and proof of death. The proceeds of the assessment, less an amount not exceeding ten percent thereof as an allowance for expenses, must be paid to the beneficiary of the deceased member. A death benefit may not exceed the maximum amount stated in the certificate.

26.1-16-17. Notice of annual meeting - Voting rights of members. Each member of a benevolent society organized under this chapter must be notified of the time and place of the annual meetings of the society by a notice incorporated in the certificate of membership issued by the society. Each member of the society is entitled to one vote, and may vote in person or by proxy.

26.1-16-18. Incontestability of certificate - Responsibility upon suicide. A certificate of membership is incontestable after one year from its date of issue except for fraud, nonpayment of assessments, or naval or military service in time of war. Death from acute or chronic disease occurring more than one year after the date of issue of a certificate may not be a ground for nonpayment of the benefits thereunder regardless of any provision or statement contained in the application or certificate, and full payment may not be refused under any certificate when the member's death occurs from an acute, subacute, or chronic disease more than one year after the date of issue of the certificate. If a member commits suicide within one year from the date of issue of the certificate, the liability of the society is limited to an amount equal to all membership fees and assessments paid by the member.

26.1-16-19. Expense fund and mortuary fund maintained as separate funds. A benevolent society must maintain and keep two separate funds:

1. An expense fund.

2. A mortuary fund.

26.1-16-20. Expense fund - Credits - Levies. The membership fee of the society, which may be not less than one dollar nor more than

five dollars, may be used for expenses. The certificate of membership must state the percentage of death assessments, not exceeding ten percent, that may be used for expenses, and moneys received on the assessments, within the limitations of this section, must be credited to the expense fund. Expense fund assessments may be levied in accordance with the applicable provisions in the membership certificate in amounts not exceeding three dollars in any one calendar year.

26.1-16-21. Mortuary fund - Credits to and use. A benevolent society must credit to its mortuary fund that part of any postmortem assessment in excess of the amount required to pay the death claim for which the assessment was levied. If the society has more than one unit of membership, the mortuary fund must be kept separately by units. The fund must be used toward the payment of claims for deaths occurring within the unit from which the fund arose, and no assessment levy may be made unless the balance in the fund is insufficient to pay a claim on which notice and proof of death has been received. No expenses may be paid from the mortuary fund.

26.1-16-22. Notice of assessment - Contents - Cancellation of certificate - Reinstatement. The notice of assessment in each case must provide that if the member to whom the notice is directed does not make payment within the time specified therein, which may be not less than fifteen days nor more than forty-five days after the date of the notice, the member's certificate will be canceled. If payment is not made within that time, a notice of cancellation must be mailed to the member informing the member that if the assessment is not paid within ten days from the mailing of the notice of cancellation, the member's certificate will be canceled. The notice of cancellation must be mailed to the member at the member's last known address immediately after the expiration of the time specified in the notice of assessment, and proof of the mailing must be established on forms provided for that purpose by the United States postal service. If payment is not made within the time specified in the notice of cancellation, the certificate must be canceled. If payment of an assessment is made to the society subsequent to the date of cancellation of the certificate, the payment may be considered as a reinstatement fee and placed in the expense fund of the society.

26.1-16-23. Secretary of society to levy assessments - Notice to members - Distribution of proceeds of assessments. Upon approval of a claim arising from the death of a member, the secretary of the society, if the mortuary fund is insufficient to pay the claim, shall levy an assessment upon the membership in accordance with the provisions of the membership certificate of the deceased member. Notice of the assessment must be mailed to each member at the member's last post-office address as given to the secretary. The notice must state:

1. The name and address of the deceased member.

2. The maximum benefit payable upon the member's certificate.

3. The amount of the assessment.

4. The date upon which the assessment shall become delinquent.

Upon the expiration of the period within which payment of the assessment may be made and the further period specified in the notice of cancellation required under section 26.1-16-22, the secretary shall pay to the beneficiary of the deceased member the proceeds of the assessment in the secretary's possession and available for that purpose.

26.1-16-24. Annual statement required - Renewal of certificate of authority. Before February second of each year, a benevolent society must file with the commissioner an annual statement as of the previous December thirty-first. The statement must be on any forms required by the commissioner and must show:

1. All income of the society by sources.

2. All disbursements of the society detailed as to nature.

3. A listing of the assets of the society.

4. The liabilities of the society.

5. The number of members in the society.

6. Any other information required by the commissioner.

If it appears from the statement that the society has a membership at least equal in number to that required as a condition precedent to authorization and that it is otherwise qualified under the requirements of this chapter, a renewal certificate of authority must be issued on the succeeding April thirtieth. The fees for the filing of the statement and the issuance of the certificate are those specified in section 26.1-01-07.

26.1-16-25. Examination. The commissioner has the same power and authority as to visitation and examination over all benevolent societies subject to this chapter as are given to the commissioner by this title over domestic insurance companies. The society examined must pay the expenses of any examination. The commissioner may require a deposit in advance of an examination to guarantee payment of the estimated necessary expense to be incurred.

26.1-16-26. Transfer of membership. A benevolent society organized or operating under this chapter, by a two-thirds vote of its members present or voting by proxy at any annual meeting or special meeting called for that purpose, may transfer its membership to any other society or organization. Notice of the contemplated action must be mailed to each member in good standing, at the member's last known post-office address, at least fifteen days prior

to the date of the meeting, and any transfer of membership, and the conditions thereof, must have the approval of the commissioner.

26.1-16-27. Penalty. Any officer or agent of a benevolent society violating this chapter is guilty of a class A misdemeanor.

SECTION 17. Chapter 26.1-17 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-17-01. Definitions. As used in this chapter, unless the context requires otherwise:

1. "Dental service" means the general and usual service rendered and the care administered by licensed dentists.

2. "Health service" means service performed for and rendered to persons to restore, maintain, and promote personal health, to treat injuries and cure diseases, both physical and mental, by any lawful means, and includes hospital service, medical service, dental service, or optometric service, or any combination of these services. However, health service is limited to those services rendered by physicians, surgeons, practitioners, nurses, hospitals, nursing homes, or any other provider of health service who is licensed or registered under the laws of this state.

3. "Health service contract" means a contract which provides for the furnishing of one or more kinds of health service to a subscriber.

4. "Health service corporation" means a nonprofit corporation organized for the purposes of establishing a health service plan whereby one or more kinds of health service is provided to subscribers under a prepaid health service contract entitling each subscriber to certain specified health services, but does not include a health maintenance organization organized under chapter 26.1-18.

5. "Hospital service" includes bed and board, general nursing care, use of the operating room, use of the delivery room, ordinary medications and dressings, and other customary routine care, and nursing home services and health care and related services furnished by vendors of the services, but does not include the practice of medicine.

6. "Medical service" means the general and usual services rendered and care administered by physicians and oral surgeons.

7. "Optometric service" means the general and usual services rendered and care administered by practitioners.

8. "Oral surgeon" means a dentist who has met all of the formal requirements to be certified by the American board of oral surgery.

9. "Practitioner" includes an optometrist and a physician duly licensed to practice his or her profession under North Dakota law.

26.1-17-02. Nonprofit health service corporations authorized. A health service corporation must be organized under this chapter and, to the extent applicable, under chapter 10-24 for the purposes of establishing and putting into effect a health service plan whereby one or more kinds of health service is provided to subscribers under a contract entitling each subscriber to certain specified health service. Any corporation subject to this chapter is not subject to the laws of this state relating to insurance and insurance companies, except as specifically provided in such laws. This chapter applies only to corporations organized pursuant to its provisions, except as specifically provided otherwise.

26.1-17-03. Articles of incorporation and bylaws - Filing. The articles of incorporation of a health service corporation, and all amendments, are to be filed with the secretary of state. A certified copy of the articles of incorporation and the bylaws, and all amendments, is to be filed with the commissioner.

26.1-17-04. Directors - Responsibilities and qualifications. A board of directors must manage the business and affairs of a health service corporation. The board is to consist of at least nine members. The qualifications of the members are as follows:

1. A majority of the directors of a health service corporation must be persons who are providers of health services or representatives of partnerships, corporations, or associations which are providers of health services which have contracted with the health service corporation to render health services to its subscribers. If a health service provider is not an individual, its representative, who serves as a member of the board of directors, must be a director, trustee, hospital administrator, officer, partner, or member of the clinical staff of the health service provider.

2. The balance of the directors must be persons who are subscribers for health services and who have no direct affiliation with any of the health service providers.

3. Directors may be physicians who are affiliated with or are members of the same health service providers. However, a director who is not a physician may not be affiliated with or be a member of the same health service provider as another director.

4. Additional qualifications for directors may be set forth in the articles of incorporation or the bylaws of the health service corporation.

26.1-17-05. Authority of corporation writing hospital service contracts. In addition to any other powers granted by law, a health service corporation writing hospital service contracts may:

1. Enter into contracts for the rendering of hospital service to any of its subscribers with hospitals maintained and operated by the state or any of its political subdivisions, or by any corporation, association, or individual. The hospital service plan operated by the corporation may provide for hospital service and other related health services, excluding the practice of medicine, as advancements in health care and treatment warrant the extension and providing of such services and in case of emergency or expediency. All hospital and related health services provided are subject to the approval of the health service corporation.

2. Make and enter into mutual agreements with hospitals or groups of hospitals, nursing homes, and other vendors and furnishers of health care services and other related facilities, excluding the practice of medicine.

3. Make and enter into mutual agreements with state, federal, or other governmental agencies to provide hospital services, nursing home care, and other related health services, excluding the practice of medicine, including health care services for the needy and other persons.

4. Make and enter into mutual agreements with any other health care corporation or with any state or local government or agency thereof to provide health care administrative services, to act as administrator of any other health care service plan, or to act as a marketing agency or as a fiscal intermediary of any health care plan or of any other health care organization or of any state or local government or agency.

5. Enter into contracts with other corporations or other entities in this state or in other states or possessions of the United States, or of the Dominion of Canada or other foreign countries so that:

   a. Reciprocity of benefits may be provided to subscribers.

   b. Transfer of subscribers from one entity to another may be effected to conform to the subscriber's place of residence.

c. Uniform benefits may be provided for all employees and dependents of such employees of entities and other organizations transacting business in this state and elsewhere and a rate representing the composite experience of the areas involved may be charged for such employees and their dependents.

d. Health services may be provided for subscribers of this or other corporations or entities for the purpose of ceding or accepting reinsurance or of jointly providing benefits, underwriting, pooling, mutualization, equalization, and other joint undertakings which the governing board may from time to time approve.

26.1-17-05.1. Authority of corporation writing medical service contracts. A health service corporation writing medical service contracts may:

1. Enter into contracts with subscribers whereby each subscriber, subscriber member, officer, or employee is entitled to certain specified health services as provided in the subscriber's contract.

2. Enter into contracts with similar corporations within or without the state for the interchange of services to those included in subscription or other similar contracts, and may provide subscription contracts for the substitution of such services in lieu of those therein recited.

3. Enter into contracts with physicians for the rendering of medical service to subscribers in accordance with the terms of the subscriber contract.

4. Enter into contracts with laboratories and vendors of health appliances and prostheses to provide material and services pursuant to contracts with subscribers.

26.1-17-06. Authority of corporation writing optometric service contracts. A health service corporation writing optometric service contracts may:

1. Enter into contracts with subscribers whereby each subscriber, subscriber member, officer, or employee is entitled to certain specified health services as provided in the subscriber's contract.

2. Enter into contracts with similar corporations within or without the state for the interchange of services to those included in subscription or other similar contracts, and may provide subscription contracts for the substitution of such services in lieu of those therein recited.

3. Enter into contracts with practitioners for the rendering of optometric service to subscribers in accordance with the terms of the subscriber contract.

4. Enter into contracts with optical laboratories to provide material pursuant to contracts with subscribers.

26.1-17-07. Authority of corporation writing certain health service contracts. A health service corporation writing health service contracts other than hospital service, medical service, and optometric service contracts may:

1. Enter into contracts with subscribers whereby each subscriber, subscriber member, officer, or employee is entitled to certain specified health services as provided in the subscriber's contract.

2. Enter into contracts with similar corporations within or without the state for the interchange of services to those included in subscription or other similar contracts, and may provide subscription contracts for the substitution of such services in lieu of those therein recited.

3. Enter into contracts with health service providers for the rendering of health services to subscribers in accordance with the terms of the subscriber contract.

4. Enter into contracts with laboratories and vendors of health appliances and prostheses to provide material and services pursuant to contracts with subscribers.

26.1-17-08. Corporation not authorized to practice a profession. This chapter does not authorize a health service corporation to engage in the practice of medicine, dentistry, optometry, or any other profession for which a license or registration is required.

26.1-17-09. Capital - Repayment. A health service corporation writing hospital service contracts or medical service contracts may not commence business and enter into any contracts with subscribers, nor secure any application therefor, unless the corporation has a contributed surplus of not less than one hundred thousand dollars. A health service corporation writing health service contracts other than hospital service or medical service contracts may not enter into any contracts with any subscribers, nor secure any application therefor, unless the corporation has a contributed surplus of not less than twenty-five thousand dollars. The contributed surplus is repayable when the unassigned earned surplus exceeds the amount required to be initially paid in as contributed surplus, only if the payment does not impair the working capital of the health service corporation.

26.1-17-10. Nonprofit corporation tax exempt - Law governing charitable organizations applicable. Every nonprofit health service corporation is a charitable and benevolent organization and is exempt from taxation

by the state or any political subdivision thereof, except that the real property of a nonprofit health service corporation is subject to ad valorem taxes and special assessments for special improvements. Except as otherwise provided in this chapter, the laws of this state relating to and affecting nonprofit charitable and benevolent corporations are applicable to all nonprofit health service corporations writing health service contracts.

26.1-17-11. Applicability of portion of Nonprofit Corporation Act. Unless in conflict with this chapter, chapters 10-24, 10-25, 10-26, and 10-28 apply to the incorporation, operation, and control of any nonprofit health service corporation.

26.1-17-12. Contract limitations. Every physician, oral surgeon, dentist, or practitioner licensed and registered in the state of North Dakota has the right to contract with any health service corporation for furnishing general or special medical care, dental care, or optometric care, as the case may be. A corporation may not impose any restriction as to the methods of diagnosis or treatment. The private relationship of physician and patient, dentist and patient, or practitioner and patient is to be maintained at all times and the subscriber has the right of free choice in selecting any physician, oral surgeon, dentist, or practitioner.

A health service corporation may, in its discretion, by its articles of incorporation, articles of association, or bylaws, and in its contract with its subscribers, limit the benefits that the corporation will furnish, and may provide for a division of benefits it agrees to furnish into classes or kinds. In the absence of any limitation or division of services, a corporation may provide both general and special medical and surgical, dental, or optometric care benefits, including such service as may necessarily be incident to such care. A corporation may, in its discretion, limit the issuance of contracts as specified in its bylaws.

A dental or optometric service contract by a health service corporation may not provide the payment of any cash indemnification by the corporation to the subscriber or the subscriber's estate on account of death, illness, or other injury.

26.1-17-13. Group medical service contracts - Options required. A health service corporation may not deliver, issue, execute, or renew any medical service contract on a group, blanket, franchise, or association basis unless the corporation makes available, at the option of the subscriber, the following coverages for which an additional premium may be charged:

1. All drugs and medicines prescribed by the provider of health services.

2. Services rendered and care administered by chiropractors licensed under chapter 43-06.

26.1-17-14. Prisoner's coverage to continue - Conditions. Every health service corporation must continue coverage of a prisoner insured under a health service contract while the prisoner is incarcerated and under state supervision to the same extent as the general public is covered as long as the prisoner meets all the other usual qualifications for insurability and continues to pay the contract premiums. A prisoner's incarceration may never be a basis for cancellation of the prisoner's health service contract.

26.1-17-15. Juvenile's coverage to continue - Conditions. Every health service corporation must continue coverage of a juvenile insured under a health service contract while the legal custody of the juvenile has been given by a court, under chapter 27-20, to any state institution or agency, to the same extent as the general public is covered as long as the juvenile meets all the other usual qualifications for insurability and continues to pay the contract premiums. A juvenile's incarceration may never be a basis for cancellation of the juvenile's health service contract.

26.1-17-16. Services of physicians, oral surgeons, dentists, and practitioners not participating under health service plan. A medical service plan may provide for medical services to subscribers by physicians and oral surgeons not participating under the plan, subject to the approval of the board of directors of the health service corporation. A dental service plan may provide for dental services to subscribers by dentists not participating under the plan, subject to the approval of the board of directors of the health service corporation. An optometric service plan may provide for optometric services to subscribers by practitioners not participating under the plan, subject to the approval of the board of directors of the health service corporation.

Where a subscriber patient is referred by a participating physician to a nonparticipating physician, the health service corporation is to pay, without the approval of the board of directors of the corporation, to the subscriber, upon proper filing of the claim, an amount equal to the amount lawfully charged for the service performed by the nonparticipating physician, but not to exceed an amount equal to one hundred percent of the maximum amount which the corporation would be obligated to pay to a participating physician for identical service.

26.1-17-17. Coordination of benefit provisions. Group health service contracts may contain coordination of benefit provisions for the control of overinsurance. These provisions must be in accordance with appropriate guidelines set forth in rules adopted by the commissioner.

26.1-17-18. Health service corporation contracts - Approval by commissioner. Contracts between a health service corporation and health service providers and contracts between a health service corporation and subscribers for health service at all times are subject to the approval of the commissioner.

26.1-17-19. Effects of health service contracts. The issuance of a health service contract by a health service corporation to a subscriber does not create the relationship of hospital and patient, physician and patient, dentist and patient, practitioner and patient, or any other similar relationship between the corporation and the subscriber. The subscriber at all times has the right to select any participating hospital, physician, oral surgeon, dentist, practitioner, or health service provider, subject to the terms and conditions of the contract. An employee, agent, officer, or member of the board of directors of any such corporation may not influence or attempt to influence any subscriber in the choosing and selecting of the hospital, physician, oral surgeon, dentist, practitioner, or other health service provider who is to care for or treat the subscriber. A civil action arising out of the relationship of hospital and patient, physician and patient, dentist and patient, practitioner and patient, or health service provider and patient may not be maintained against any health service corporation governed by this chapter. A participating practitioner has the right to engage in other practice.

26.1-17-20. Dental and optometric service in accordance with prevailing practice - Emergency service. All dental or optometric care rendered to a subscriber under the subscriber's contract must be in accordance with the accepted standards of dental or optometric practice prevailing in the community in which the service is rendered.

All service must be rendered by dentists and practitioners duly licensed and registered to practice their profession in this state, except that in case of emergency, and subject to the approval of the board of directors of the health service corporation, the benefits to which a subscriber is entitled under the subscriber's contract may be rendered in another state, provided the services are rendered by a duly licensed dentist or duly licensed practitioner in the other state.

26.1-17-21. Limitations on dental and optometric service contracts. Every subscriber under a dental or optometric service plan must receive a copy of the contract. The contract must clearly state the care, appliances, materials, and supplies to be provided under the contract and the rate charged the subscriber. Every subscriber must have, at all times, free choice of the dentist or practitioner who is to treat the subscriber, and this right must be prominently printed in the contract. Every optometric service contract must provide that a subscriber has the freedom of choice to have the materials and supplies furnished by any practitioner or optician, the cost for which is to be covered in accordance with the terms of the contract. A health service corporation may not enter into any contract, agreement, or understanding, directly or indirectly, with any dentist or practitioner whereby the dentist or practitioner is to render any services to any subscriber, but all such services must be a matter of agreement directly between the patient and the dentist or practitioner selected by the patient to treat the patient.

26.1-17-22. Health service for needy persons - Payments. A health service corporation may contract with state, federal, or other governmental agencies, private agencies, corporations, associations, groups, or individuals to provide health services for needy or other persons. A health service corporation may receive from these entities payments covering the cost of all or any part of the contracts.

26.1-17-23. Licensing of sales representatives. The sales representatives of any health service corporation are subject to the laws pertaining to insurance agents as defined in chapter 26-17.1. The commissioner shall prescribe the form for the license or certificate. The fee for a license or certificate is three dollars.

Sales representatives licensed to sell hospital service contracts may also sell all other health service contracts without further licensure.

26.1-17-24. Unfair insurance practices. Chapter 26.1-04 applies to health service corporations and contracts with hospitals, doctors of medicine and oral surgeons, dentists, practitioners, health service providers, and subscribers, except to the extent that the commissioner determines that the nature of health service corporations, or of any contracts issued or entered into by those corporations, renders chapter 26.1-04 clearly inappropriate.

26.1-17-25. Rates, rating formulas, and rating systems subject to approval of commissioner. Rates charged subscribers, and rating formulas and rating systems used to determine rates, are at all times subject to the approval of the commissioner in the manner prescribed by this chapter. Rates must cover reasonably anticipated claims, cover reasonable costs of operation and overhead expenses, and maintain contingency reserves at a proper level of not less than the sum of incurred claims and operating and overhead expenses for at least two months, but not more than four months. Rates may not be excessive, inadequate, or unfairly discriminatory.

26.1-17-26. Rate filings.

1. Each health service corporation must file with the commissioner every manual of classifications, rates, rating formulas, rating systems, and rules applicable thereto, and any modification of the foregoing which it proposes to use. Each filing must state the proposed effective date thereof and must indicate the character and extent of the coverage contemplated. Where a filing is not accompanied by supporting information, and the commissioner does not have sufficient information to determine whether the filing meets the requirements of this chapter, the commissioner shall require the corporation to furnish supporting information, and the waiting period will commence on the date the information is furnished. The information furnished in support of a filing must include (a) contract of benefits; (b) current

rate structure; (c) claims experience for most recent period up to three years; (d) claims experience projection for next eighteen months; (e) letter of opinion from the corporation actuary; and (f) judgment of the corporation and its interpretation of the supporting data.

A filing and any supporting information is open to public inspection after the filing becomes effective.

2. The commissioner shall review the filings as soon as reasonably possible after they have been made and within the waiting period and the extension thereof, if any, in order to determine whether they meet the requirements of this chapter.

3. Each filing shall be on file for a waiting period of thirty days before it becomes effective. The commissioner may extend the waiting period for an additional period not to exceed fifteen days if the commissioner gives written notice within the original waiting period to the filing health service corporation that the commissioner needs additional time to consider the filing.

Upon written application by the corporation, the commissioner may authorize a filing which the commissioner has reviewed to become effective before the expiration of the waiting period or any extension thereof. A filing shall be deemed to meet the requirements of this chapter unless disapproved by the commissioner within the waiting period or any extension thereof.

4. Under the rules the commissioner has adopted, the commissioner may, by written order, suspend or modify the requirements of filing as to any kind of contract for health services, subdivision thereof, or combination thereof, or as to any class of risks, the rates for which cannot practically be filed before they are used. The orders and rules must be made known to the health service corporation affected. The commissioner may make an examination as the commissioner deems advisable to ascertain whether any rates affected by an order meet the standards set forth in section 26.1-17-25.

26.1-17-27. Disapproval of rate filings.

1. If within the waiting period or any extension thereof, as provided in subsection 3 of section 26.1-17-26, the commissioner finds that a rate filing does not meet the requirements of this chapter, the commissioner shall send to the health service corporation which made the filing written notice of disapproval of the filing, specifying in what respects the commissioner finds the filing fails to meet the requirements of this chapter and stating that the filing may not become effective.

2. If at any time subsequent to the applicable waiting period or extension thereof the commissioner finds that a rate filing does not meet the requirements of this chapter, the commissioner shall, after a hearing held upon not less than ten days' written notice specifying the matters to be considered at the hearing to every health service corporation which made the filing, issue an order specifying in what respects the commissioner finds that the filings fail to meet the requirements of this chapter, and stating the date, within a reasonable period thereafter, as of which the filings are deemed to be no longer effective. Copies of the order must be sent to the corporation.

3. Any person or organization aggrieved with respect to any filing which is in effect, except the health service corporation which made the filing, may make written application to the commissioner for a hearing thereon. The application must specify the grounds relied upon by the applicant. If the commissioner finds that the application is made in good faith, that the applicant would be so aggrieved if the applicant's grounds were established, and that the grounds otherwise justify holding a hearing, the commissioner shall, within thirty days after receipt of the application, hold a hearing upon not less than ten days' written notice to the applicant and to each corporation which made the filing. If after a hearing the commissioner finds that the filing does not meet the requirements of this chapter, the commissioner shall issue an order specifying the findings and stating the date, within a reasonable period thereafter, as of which the filing is deemed to be no longer effective. Copies of this order must be sent to the applicant and to each corporation.

4. A manual of classifications, rules, rating plans, rating formulas, or modifications of any of the foregoing which establish standards for measuring variations in hazards or expense provisions, or both, and which has been filed pursuant to the requirements of section 26.1-17-26, may not be disapproved if the rates thereby produced meet the requirements of this chapter.

26.1-17-28. Information to be furnished subscribers - Hearings and appeals of subscribers. Each health service corporation must, within a reasonable time after receiving a written request therefor, furnish to any subscriber with whom it has a contract and who is affected by a rate made by it, or to the authorized representative of the subscriber, all pertinent information as to the rate.

Each corporation must provide reasonable means whereby any person aggrieved by the application of its rating system, rating formula, or rate may be heard in person or through that person's authorized representative on that person's written request to review

the manner in which the rating system, rating formula, or rate has been applied in connection with the contract issued to that person. If the corporation fails to grant or reject the request within thirty days after it is made, the applicant may proceed in the same manner as if the application has been rejected. Any party affected by the action of a corporation on such request may, within thirty days after written notice of the action, appeal to the commissioner who, after hearing held upon not less than ten days' written notice to the appellant and to the corporation, may affirm or reverse the action.

26.1-17-29. False or misleading information - Penalty. A subscriber under a health service contract or a health service corporation may not willfully withhold information from, or give false or misleading information to, the commissioner or any statistical agency designated by the commissioner, where the information given or withheld will affect the rates or premiums chargeable under this chapter. Any subscriber or corporation who violates this section is guilty of an infraction.

26.1-17-30. Investment of funds. The funds of any health service corporation may be invested only in those investments authorized to be made by domestic insurance companies of this state. Investments made prior to July 1, 1983, are subject to the requirements for authorized investments prior to July 1, 1983, and not to the requirements for authorized investments after July 1, 1983.

26.1-17-31. Annual statement. Every health service corporation must annually before April second file in the office of the commissioner, a verified statement signed by at least two of its principal officers, showing the condition of its affairs on the preceding December thirty-first. The statement must be in the form and must contain the information prescribed by the commissioner.

26.1-17-32. Investigation and examination. The commissioner, or any deputy or examiner designated by the commissioner, has the right, at all reasonable times, to free access to all books and records of a health service corporation, and may summon and examine, under oath, the officers and employees of the corporation in all matters pertaining to its financial condition. The corporation must bear the expense of any examination of its books and financial condition.

26.1-17-33. Liquidation - Dissolution - Merger - Consolidation. Any involuntary liquidation and dissolution of a health service corporation is governed by chapter 26.1-07. Any voluntary liquidation and dissolution is governed by chapter 10-26. Any merger or consolidation of a health service corporation is subject to the approval of the commissioner in accordance with the procedures set forth in chapter 26.1-07, but the consolidation or merger must be accomplished under chapter 10-25.

26.1-17-34. Hearing procedure and judicial review.

1. Any health service corporation aggrieved by any order or decision of the commissioner made without a hearing may, within thirty days after notice of the order to the corporation, make written request to the commissioner for a hearing thereon. The commissioner shall hear the party within twenty days after receipt of the request and shall give not less than ten days' written notice of the time and place of the hearing. Within fifteen days after the hearing, the commissioner shall affirm, reverse, or modify the previous action specifying the reasons therefor. Pending a hearing and decision thereon, the commissioner may suspend or postpone the effective date of the previous action.

2. This chapter does not require the observance at any hearing of formal rules of pleading or evidence.

SECTION 18. Chapter 26.1-18 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-18-01. Definitions. As used in this chapter:

1. "Agent" means a person directly or indirectly associated with a health care plan who engages in solicitation or enrollment.

2. "Basic health care services" means health care services which an enrolled population might reasonably require in order to be maintained in good health, including as a minimum, emergency care, inpatient hospital and physician care, and outpatient medical services.

3. "Enrollee" means a natural person who has been enrolled in a health care plan.

4. "Evidence of coverage" means any certificate, agreement, or contract issued to an enrollee setting out the coverage to which the enrollee is entitled.

5. "Health care plan" means any arrangement whereby any person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services and at least part of the arrangement consists of arranging for, or the provision of, health care services, as distinguished from mere indemnification against the cost of health care services, on a prepaid basis through insurance or otherwise.

6. "Health care services" means any services included in the furnishing to any individual of medical or dental care, or hospitalization or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person of any and all other services for the purpose of

preventing, alleviating, curing, or healing human illness or injury.

7. "Health maintenance organization" means any person who undertakes to provide or arrange for one or more health care plans.

8. "Provider" means any physician, hospital, or other person which is licensed or otherwise authorized in this state to furnish health care services.

26.1-18-02. Health maintenance organizations authorized - Compliance with chapter. Notwithstanding any law of this state to the contrary, any person may apply to the commissioner for and obtain a certificate of authority to establish and operate a health maintenance organization in compliance with this chapter. A person may not establish or operate a health maintenance organization in this state, or sell, offer to sell, or solicit offers to purchase or receive advance or periodic consideration in conjunction with a health maintenance organization without obtaining a certificate of authority under this chapter. A foreign corporation may similarly apply for a certificate of authority under this chapter, subject to its registration to do business in this state as a foreign corporation under chapter 10-22.

Every health maintenance organization operating in this state as of July 1, 1975, must submit an application for a certificate of authority under section 26.1-18-03 before August 1, 1975. The applicant may continue to operate until the commissioner acts upon its application. If the application is denied under section 26.1-18-06, the applicant must be treated as a health maintenance organization whose certificate of authority has been revoked.

26.1-18-03. Application for certificate of authority - Form - Contents. The application for a certificate of authority must be verified by an officer or authorized representative of the applicant, must be in a form prescribed by the commissioner, and must set forth or be accompanied by:

1. A copy of the basic organizational document, if any, of the applicant such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto.

2. A copy of the bylaws, rules, regulations, or similar document, if any, regulating the conduct of the internal affairs of the applicant.

3. A list of the names, addresses, and official positions of the persons who are to be responsible for the conduct of the affairs of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the

principal officers in the case of a corporation, and the partners or members in the case of a partnership or association.

4. A copy of any contract made or to be made between any providers or persons listed in subsection 3 and the applicant. This subsection does not apply to contracts between individual providers, groups of providers, individual providers and groups of providers, or between other persons who are not applicants.

5. A statement generally describing the health maintenance organization, its health care plan or plans, its facilities, and its personnel.

6. A copy of the form of evidence of coverage to be issued to each enrollee.

7. A copy of the form of group contract, if any, which is to be issued to the employer, union, trustees, or other organization.

8. Financial statements showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent regular certified financial statement satisfies this requirement unless the commissioner directs that additional or more recent financial information is required for the proper administration of this chapter.

9. A description of the proposed method of marketing the plan.

10. A description of a financial plan which includes a three-year projection of the initial operating results anticipated, and a statement as to the sources of working capital as well as any other sources of funding.

11. A power of attorney duly executed by the applicant, if not domiciled in this state, appointing the commissioner and the commissioner's successors in office, and duly authorized deputies, as the true and lawful attorney of the applicant in and for this state upon whom all lawful process may be served in any legal action or proceeding against the health maintenance organization on a cause of action arising in this state.

12. A statement reasonably describing the geographic area or areas to be served.

13. A description of the complaint procedures to be utilized as required under this chapter.

14. A description of the procedures and programs to be implemented to meet the quality of health care requirements in section 26.1-18-05.

15. A description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of policy and operation under section 26.1-18-08.

16. Any other information the commissioner requires to make the determinations required under sections 26.1-18-05 and 26.1-18-06.

26.1-18-04. Notice of modification - Filing. A health maintenance organization must, unless otherwise provided in this chapter, file a notice describing any modification of the operation set out in the information required by section 26.1-18-03. The notice must be filed with the commissioner prior to effecting the modification. If the commissioner does not disapprove within fifteen days of filing, the modification is deemed approved.

The commissioner may adopt rules exempting those items the commissioner deems unnecessary from the filing requirements of this section.

26.1-18-05. Application for certificate of authority - Review procedure - Department of health. Upon receipt of an application for issuance of a certificate of authority, the commissioner shall forthwith transmit copies of the application and accompanying documents to the state department of health.

The state department of health must determine whether the applicant for a certificate of authority, with respect to health care services to be furnished:

1. Has demonstrated the willingness and potential ability to assure that the health care services will be provided in a manner to assure both availability and accessibility of adequate personnel and facilities and in a manner enhancing availability, accessibility, and continuity of service.

2. Has established arrangements, in accordance with rules adopted by the department, for an ongoing quality of health care assurance program concerning health care processes and outcomes.

3. Has established a procedure, in accordance with rules adopted by the department, to develop, compile, evaluate, and report statistics relating to the cost of its operations, the pattern of utilization of its services, the availability and accessibility of its services, and any other matters reasonably required by the department.

Within thirty days of receipt of the application for issuance of a certificate of authority, the state department of health must certify to the commissioner whether the proposed health maintenance organization meets the requirements of this section. If the department certifies that the health maintenance organization does not meet the requirements, it must specify in what respects it is deficient.

26.1-18-06. Review of application by commissioner - Issuance of certificate of authority. The commissioner shall issue or deny a certificate of authority to any person filing an application pursuant to section 26.1-18-03 within ninety days following receipt of the certification from the state department of health given pursuant to section 26.1-18-05. The certificate of authority must be issued upon payment of the application fee prescribed if the commissioner is satisfied that the following conditions are met:

1. The persons responsible for the conduct of the affairs of the applicant are honest, competent, and trustworthy.

2. The state department of health certifies, in accordance with section 26.1-18-05, that the health maintenance organization's proposed plan of operation meets the requirements of that section.

3. The health care plan constitutes an appropriate mechanism whereby the health maintenance organization will effectively provide or arrange for the provision of basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for copayments.

4. The health maintenance organization is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the commissioner may consider:

   a. The financial soundness of the health care plan's arrangements for health care services.

   b. A schedule of premium rates with supporting actuarial and other data.

   c. The adequacy of working capital.

   d. Any agreement with an insurer, a health service corporation, a government, or any other organization for insuring the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage in the event of discontinuance of the plan.

   e. Any agreement with providers for the provision of health care services. This subsection does not apply

to agreements between individual providers, groups of providers, individual providers and groups of providers, or between other persons who are not applicants.

f. Any surety bond or deposit of cash or securities submitted in accordance with section 26.1-18-23 as a guarantee that the obligations will be duly performed.

5. The enrollees will be afforded an opportunity to participate in matters of policy and operation pursuant to section 26.1-18-08.

6. Nothing in the proposed method of operation, as shown by the information submitted pursuant to section 26.1-18-03 or by independent investigation, is contrary to the public interest.

7. Any deficiencies certified by the state department of health have been corrected.

Denial of a certificate of authority is effective only after compliance with the requirements of section 26.1-18-30.

26.1-18-07. Powers of organization - Review by commissioner - Filing of notice - Disapproval - Rules. The powers of a health maintenance organization include the following:

1. The purchase, lease, construction, renovation, operation, or maintenance of hospitals, medical facilities, or both, and their ancillary equipment, and such property as may reasonably be required for its principal office or for such other purposes as may be necessary in the transaction of the business of the organization.

2. The making of loans to a medical group under contract with it in furtherance of its program or the making of loans to a corporation or corporations under its control for the purpose of acquiring or constructing medical facilities or hospitals or in furtherance of a program providing health care services to enrollees.

3. The furnishing of health care services through providers which are under contract with or employed by the health maintenance organization.

4. The contracting with any person for the performance on its behalf of certain functions such as marketing, enrollment, or administration.

5. The contracting with an insurance company licensed in this state, or with a health service corporation authorized to do business in this state, for the provision of insurance, indemnity, or reimbursement against the cost of health

care services provided by the health maintenance organization.

6. The offering, in addition to basic health care services, of:

   a. Additional health care services.

   b. Indemnity benefits covering out of area or emergency services.

   c. Indemnity benefits, in addition to those relating to out of area and emergency services, provided through insurers or health service corporations.

A health maintenance organization must file notice, with adequate supporting information, with the commissioner prior to the exercise of any power granted in subsection 1 or 2. The commissioner shall disapprove the exercise of power if in the commissioner's opinion it would substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations. If the commissioner does not disapprove within thirty days of the filing, it is deemed approved. The commissioner may adopt rules excepting from this filing requirement those activities having a de minimis effect.

26.1-18-08. Governing body - Participation by enrollees. The governing body of any health maintenance organization may include providers, representatives of providers, other individuals, or a combination. The governing body must establish a mechanism to afford the enrollees an opportunity to participate in matters of policy and operation through the establishment of advisory panels, by the use of advisory referenda on major policy decisions, or through the use of other mechanisms.

26.1-18-09. Fiduciary responsibilities. Any director, officer, or partner of a health maintenance organization who receives, collects, disburses, or invests funds in connection with the activities of the organization is responsible for the funds in a fiduciary relationship to the enrollees.

26.1-18-10. Licensure of agents - Rulemaking. The commissioner may adopt any reasonable rules necessary to provide for the licensing of agents.

26.1-18-11. Commissioner may require official bond of officers and employees. If the commissioner deems it necessary for the security of the funds of a health maintenance organization, the commissioner may require an official bond of each officer and each employee of the organization in an amount not to exceed the sum of money for which each is accountable.

26.1-18-12. Evidence of coverage - Filing of forms and amendments - Contents - Exception. Every enrollee residing in this state is

entitled to evidence of coverage under a health care plan. If the enrollee obtains coverage under a health care plan through an insurance policy or a contract issued by a health service corporation, whether by option or otherwise, the insurer or the health service corporation must issue the evidence of coverage. Otherwise, the health maintenance organization must issue the evidence of coverage.

An evidence of coverage, or amendment thereto, may not be issued or delivered to any person in this state until a copy of the form of the evidence of coverage, or amendment thereto, has been filed with and approved by the commissioner.

An evidence of coverage must contain:

1. No provision or statement which is unjust, unfair, inequitable, or which encourages misrepresentation, or which is untrue, misleading, or deceptive as defined in section 26.1-18-24.

2. A clear and complete statement, if a contract, or a reasonably complete summary, if a certificate, of:

   a. The health care services and the insurance or other benefits, if any, to which the enrollee is entitled under the health care plan.

   b. Any limitations on the services, kinds of services, benefits, or kinds of benefits, to be provided, including any deductible or copayment feature.

   c. Where and in what manner information is available as to how services may be obtained.

   d. The total amount of payment for health care services and the indemnity or service benefits, if any, which the enrollee is obligated to pay with respect to an individual contract, and an indication whether the plan is contributory or noncontributory with respect to group contracts.

   e. A clear and understandable description of the health maintenance organization's method of resolving enrollee complaints.

Any subsequent change may be evidenced in a separate document issued to the enrollee.

A copy of the form of evidence of coverage to be used in this state, and any amendment thereto, is subject to the filing and approval requirements of this section unless it is subject to the jurisdiction of the commissioner under the laws governing health insurance companies or health service corporations in which event the filing and approval provisions of those laws apply. To the

extent, however, that those provisions do not apply, the requirements in this section are applicable.

26.1-18-13. Coordination of benefits provision. Group health maintenance organization contracts may contain coordination of benefits or other insurance provisions for the control of overinsurance. The provisions must be in accordance with rules adopted by the commissioner.

26.1-18-14. Filing and approval of schedule of charges. A schedule of charges for enrollee coverage for health care services, or amendment thereto, may not be used in conjunction with any health care plan until a copy of the schedule, or amendment thereto, has been filed with and approved by the commissioner.

The charges must be established in accordance with actuarial principles for various categories of enrollees; provided, that charges applicable to an enrollee may not be individually determined and based on the status of the enrollee's health or physical disability. The charges may not be excessive, inadequate, or unfairly discriminatory. A certification, by a qualified actuary, to the appropriateness of the charges, based on reasonable assumptions, must accompany the filing along with adequate supporting information. For this purpose, a qualified actuary means a member of the American academy of actuaries or any other actuary who may be approved for this purpose by the commissioner.

26.1-18-15. Disapproval of forms or charges - Procedure. The commissioner shall, within a reasonable period, approve any form if the requirements of section 26.1-18-12 are met and any schedule of charges if the requirements of section 26.1-18-14 are met. It is unlawful to issue any form or to use any schedule of charges until approved. If the commissioner disapproves the filing, the commissioner shall notify the person filing. In the notice, the commissioner shall specify the reasons for disapproval. A hearing must be granted within fifteen days after a request in writing by the person filing. If the commissioner does not disapprove any form or schedule of charges within thirty days of the filing of the form or charges, the form or schedule is deemed approved.

26.1-18-16. Filing of relevant information - Authority of commissioner. The commissioner may require the submission of whatever relevant information the commissioner deems necessary in determining whether to approve or disapprove a filing made pursuant to sections 26.1-18-12, 26.1-18-14, and 26.1-18-15.

26.1-18-17. Complaint system - Approval of commissioner - Annual report - Contents - Examinations.

1. A health maintenance organization must establish and maintain a complaint system which has been approved by the commissioner, after consultation with the state department of health, to provide reasonable procedures for the

resolution of written complaints initiated by enrollees concerning health care services.

2. A health maintenance organization must submit to the commissioner and the state department of health an annual report in a form prescribed by the commissioner, after consultation with the state department of health, which must include:

   a. A description of the procedures of the complaint system.

   b. The total number of complaints handled through the complaint system and a compilation of causes underlying the complaints filed.

   c. The number, amount, and disposition of malpractice claims during the year filed by enrollees of the health maintenance organization against the health maintenance organization and any of the providers used by it.

3. A health maintenance organization must maintain records of written complaints filed with it concerning other than health care services and must submit to the commissioner a summary report at the times and in the format required by the commissioner. The complaints involving other persons must be referred to the persons with a copy to the commissioner.

4. The commissioner or the state department of health, or both, may examine the complaint system.

26.1-18-18. Annual report - Form prescribed by commissioner. Every health maintenance organization must annually, on or before March first, file a report, verified by at least two principal officers, with the commissioner with a copy to the state department of health covering the preceding calendar year. The report must be on forms prescribed by the commissioner and must include:

1. A financial statement of the organization, including its balance sheet and receipts and disbursements for the preceding year certified by an independent public accountant.

2. Any material changes in the information submitted pursuant to section 26.1-18-03.

3. The number of persons enrolled during the year, the number of enrollees terminated during the year, and the number of enrollees as of the end of the year.

4. A summary of information compiled pursuant to section 26.1-18-05 in the form required by the state department of health.

5. Any other information relating to the performance of the health maintenance organization necessary to enable the commissioner to carry out the commissioner's duties under this chapter.

26.1-18-19. Fees. Every health maintenance organization must pay to the commissioner a fee as provided in section 26.1-01-07 for filing an application for a certificate of authority or amendment thereto and for filing each annual report.

26.1-18-20. Information furnished to enrollees. Every health maintenance organization must annually provide to its enrollees:

1. The most recent annual statement of financial condition including a balance sheet and summary of receipts and disbursements.

2. A description of the organizational structure and operation of the health care plan and summary of any material changes since the issuance of the last report.

3. A description of services and information as to where and how to secure them.

4. A clear and understandable description of the health maintenance organization's method for resolving enrollee complaints.

26.1-18-21. Open enrollment - Limiting membership. After a health maintenance organization has been in operation five years, it must have an annual open enrollment period of at least one month during which it accepts enrollees up to the limits of its capacity, as determined by the health maintenance organization, in the order in which they apply for enrollment. A health maintenance organization may apply to the commissioner for authorization to impose any underwriting restrictions upon enrollment which are necessary to preserve its financial stability, to prevent excessive adverse selection by prospective enrollees, or to avoid unreasonably high or unmarketable charges for enrollee coverage for health care services. The commissioner shall approve or disapprove the application within thirty days of its receipt from the health maintenance organization.

Health maintenance organizations providing or arranging for services exclusively on a group contract basis may limit the open enrollment to all members of the group or groups covered or to be covered by the contracts.

26.1-18-22. Authorized investments. With the exception of investments made in accordance with subsections 1 and 2 of section 26.1-18-07, the investable funds of a health maintenance

organization may be invested only in securities or other investments permitted by the laws of this state for the investment of assets constituting the legal reserves of life insurance companies or any other securities or investments the commissioner permits.

26.1-18-23. Protection against insolvency - Deposit of bond, cash, or securities. A health maintenance organization must furnish a surety bond in an amount satisfactory to the commissioner or deposit with the commissioner cash or securities acceptable to the commissioner in at least the same amount, as a guarantee that the obligations to the enrollees will be performed. The commissioner may waive this requirement whenever satisfied that the assets of the organization or its contracts with insurers, health service corporations, governments, or other organizations are such as to reasonably assure the performance of its obligations.

26.1-18-24. Prohibited practices - Advertising and solicitation - Cancellation of enrollees - Name of organization. A health maintenance organization, or representative thereof, may not cause or knowingly permit the use of advertising which is untrue or misleading, solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. For the purposes of this section:

1. A statement or item of information is untrue if it does not conform to fact in any respect which is or may be significant to an enrollee of, or person considering enrollment in, a health care plan.

2. A statement or item of information is misleading, whether or not it may be literally untrue, if, in the total context in which the statement is made or the item of information is communicated, the statement or item of information may be reasonably understood by a reasonable person, not possessing special knowledge regarding health care coverage, to indicate the existence of any benefit or advantage or the absence of any exclusion, limitation, or disadvantage of possible significance to an enrollee of, or person considering enrollment in, a health care plan, if the benefit or advantage or absence of limitation, exclusion, or disadvantage does not in fact exist.

3. An evidence of coverage is deceptive if the evidence of coverage taken as a whole, and with consideration given to typography and format, as well as language, causes a reasonable person, not possessing special knowledge regarding health care plans and evidences of coverage, to expect benefits, services, charges, or other advantages which the evidence of coverage does not provide or which the health care plan issuing the evidence of coverage does not regularly make available to enrollees covered under the evidence of coverage.

An enrollee may not be canceled or nonrenewed except for the failure to pay the proper premium for coverage, actual or

constructive fraud or flagrant abuse by the enrollee of the provisions of the health care plan, inability to maintain a therapeutic relationship with any of the health maintenance organization's primary care physicians, or for other reasons as may be adopted by rule by the commissioner.

A health maintenance organization, unless licensed as an insurer, may not use in its name, contracts, or literature, the words "insurance", "casualty", "surety", or "mutual", or any other words descriptive of the insurance or surety business or deceptively similar to the name or description of any insurance or surety corporation doing business in this state.

26.1-18-25. Unfair insurance practices - Application to organization. Chapter 26.1-04 applies to health maintenance organizations, health care plans, and related evidences of coverage except to the extent that the commissioner determines that the nature of health maintenance organizations, health care plans, and related evidences of coverage render the chapter or portions thereof clearly inappropriate.

26.1-18-26. Powers of insurers and health service corporations. An insurance company licensed in this state, or a health service corporation authorized to do business in this state, may either directly or through a subsidiary or affiliate organize and operate a health maintenance organization under this chapter. Notwithstanding any other law which may be inconsistent herewith, any two or more such insurance companies, health service corporations, or subsidiaries or affiliates thereof, may jointly organize and operate a health maintenance organization. The business of insurance is deemed to include the providing of health care by a health maintenance organization owned or operated by an insurer or a subsidiary thereof.

Notwithstanding any provision of insurance or health service corporation laws, an insurer or a health service corporation may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through health maintenance organizations and to provide uninterrupted coverage in the event of the failure of the health maintenance organization to meet its obligations. The enrollees of a health maintenance organization constitute a permissible group under such laws. Among other rights under the contracts, the insurer or health service corporation may make benefit payments to health maintenance organizations for health care services rendered by providers pursuant to the health care plan.

26.1-18-27. Examinations by commissioner and department of health - Expenses - Acceptance of other examinations. The commissioner may examine the affairs of any health maintenance organization as often as necessary for the protection of the interests of the people of this state but not less frequently than once every three years.

The state department of health may make an examination concerning the quality of health care services of any health maintenance organization as often as necessary for the protection of the interests of the people of this state but not less frequently than once every three years.

For the purpose of examinations, the commissioner and the state department of health may administer oaths to, and examine, the officers and agents of the health maintenance organization and the principals of providers with whom the organization has contracts, agreements, or other arrangements pursuant to its health care plan. To the extent that examinations may require the disclosure of personally identifying information relating to either financial transactions or medical information concerning a plan enrollee in the records of the health maintenance organization or the records of a provider with whom the organization has contracts, agreements, or other arrangements pursuant to its health care plan, the information is to be used for the sole purpose of assessing the quality of care provided and the degree of compliance with provisions of this chapter. The information is to be held in confidence and may not be disclosed except upon the express consent of the enrollee, or pursuant to a court order for the production or discovery of evidence, or in the event of a claim or litigation between the enrollee and the health maintenance organization when the information is pertinent.

The expenses of examinations under this section must be assessed against the organization being examined and remitted to the commissioner or the state department of health for whom the examination is being conducted.

The commissioner or the state department of health may accept an examination or the report of an examination made by the commissioner or the state department of health of another state, the federal government, or an approved independent accrediting organization.

26.1-18-28. Suspension or revocation of certificate of authority - Grounds - Procedure - Duty of organization. The commissioner may suspend or revoke any certificate of authority issued to a health maintenance organization under this chapter if the commissioner finds that any of the following exist:

1. The health maintenance organization is operating significantly in contravention of its basic organizational document, its health care plan, or in a manner contrary to that described in and reasonably inferred from any other information submitted under sections 26.1-18-02, 26.1-18-03, and 26.1-18-04, unless amendments to the submissions have been filed with and approved by the commissioner.

2. The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care

services which do not comply with the requirements of sections 26.1-18-12, 26.1-18-14, 26.1-18-15, and 26.1-18-16.

3. The health care plan does not provide or arrange for basic health care services.

4. The state department of health certifies to the commissioner that:

   a. The health maintenance organization does not meet the requirements of section 26.1-18-05; or

   b. The health maintenance organization is unable to fulfill its obligations to furnish health care services as required under its health care plan.

5. The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees.

6. The health maintenance organization has failed to implement a mechanism affording the enrollees an opportunity to participate in matters of policy and operation under section 26.1-18-08.

7. The health maintenance organization has failed to implement the complaint system required by section 26.1-18-17 in a manner to reasonably resolve valid complaints.

8. The health maintenance organization, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive, or unfair manner.

9. The continued operation of the health maintenance organization would be hazardous to its enrollees.

10. The health maintenance organization has otherwise failed to substantially comply with this chapter.

A certificate of authority may be suspended or revoked only after compliance with the requirements of section 26.1-18-30.

When the certificate of authority of a health maintenance organization is suspended, the health maintenance organization may not, during the period of suspension, enroll any additional enrollees except newborn children or other newly acquired dependents of existing enrollees, and may not engage in any advertising or solicitation.

When the certificate of authority of a health maintenance organization is revoked, the organization must proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and may conduct no further business except as may be essential to the orderly conclusion of the affairs of such organization. It may not engage in any further advertising or solicitation whatsoever. The commissioner may, by written order, permit any further operation of the organization as the commissioner finds to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

26.1-18-29. Rehabilitation, liquidation, or conservation of health maintenance organization. Any rehabilitation, liquidation, or conservation of a health maintenance organization is deemed to be the rehabilitation, liquidation, or conservation of an insurance company and must be conducted under the supervision of the commissioner pursuant to the law governing the rehabilitation, liquidation, or conservation of insurance companies. The commissioner may apply for an order directing the commissioner to rehabilitate, liquidate, or conserve a health maintenance organization upon any one or more grounds set out in section 26.1-07-09.

26.1-18-30. Administrative procedures. When the commissioner has cause to believe that grounds for the denial of an application for a certificate of authority exist, or that grounds for the suspension or revocation of a certificate of authority exist, the commissioner shall notify the health maintenance organization and the state department of health in writing specifically stating the grounds for denial, suspension, or revocation and fixing a time for a hearing on the matter as provided in chapter 28-32.

The state department of health, or its designated representative, must be in attendance at the hearing and must participate in the proceedings. The recommendation and findings of the department with respect to matters relating to the quality of health care services provided in connection with any decision regarding denial, suspension, or revocation of a certificate of authority, are conclusive and binding upon the commissioner. After the hearing, or upon the failure of the health maintenance organization to appear at the hearing, the commissioner shall take action as is deemed advisable on written findings which must be mailed to the health maintenance organization with a copy to the state department of health.

26.1-18-31. Statutory construction and relationship to other laws. Except as otherwise provided in this chapter, neither provisions of the insurance laws nor provisions of health service corporation laws are applicable to any health maintenance organization issued a certificate of authority under this chapter. This provision does not apply to an insurer or health service corporation licensed and regulated pursuant to the insurance laws or the health service corporation laws of this state except with respect to its health

maintenance organization activities authorized and regulated pursuant to this chapter.

Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, does not violate any law relating to solicitation or advertising by health professionals.

Any health maintenance organization authorized under this chapter is not deemed to be practicing medicine and is excepted from the laws of this state relating to the practicing of medicine; provided, however, that all providers within the health maintenance organization are subject to the licensure laws of their respective professions.

26.1-18-32. Filings and reports are public documents - Confidentiality of medical information. All applications, filings, and reports required under this chapter are public documents. Any data or information pertaining to the diagnosis, treatment, or health of any enrollee or applicant for enrollment obtained from that person or from any provider by any health maintenance organization must be held in confidence and may not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of this chapter; or upon the express consent of the enrollee or applicant; or pursuant to statute or court order for the production of evidence or the discovery thereof; or in the event of claim or litigation between that person and the health maintenance organization wherein the data or information is pertinent. A health maintenance organization is entitled to claim any statutory privileges against disclosure which the provider who furnished the information to the health maintenance organization is entitled to claim.

26.1-18-33. Department of health's authority to contract. The state department of health, in carrying out its obligations under sections 26.1-18-05, 26.1-18-27, and 26.1-18-28, may contract with qualified persons to make recommendations concerning the determinations required to be made by it.

26.1-18-34. Rulemaking authority of commissioner. The commissioner may adopt reasonable rules necessary and proper to carry out this chapter.

26.1-18-35. Administrative fine - Criminal penalty. The commissioner may, in lieu of suspension or revocation of a certificate of authority under section 26.1-18-28, levy an administrative penalty in an amount not less than five hundred dollars nor more than ten thousand dollars, if reasonable notice is given of the intent to levy the penalty and the health maintenance organization has a reasonable time within which to remedy the defect in its operations which gave rise to the penalty citation.

Any person who violates this chapter is guilty of a class A misdemeanor.

SECTION 19. Chapter 26.1-19 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-19-01. Interpretation. This chapter must be interpreted liberally to achieve the following purposes:

1. To encourage development of effective and economic methods of making legal services available to the public in this state.

2. To allow development of legal service plans and encourage experimentation with innovation methods of organizing and administering those plans.

3. To encourage competition among the various entities organized under this statute.

4. To ensure maintenance of a high level of competence and adherence to professional standards.

26.1-19-02. Definitions. As used in this chapter:

1. "Evidence of coverage" means any certificate, agreement, or contract issued to a participant setting out the coverage to which the participant is entitled.

2. "Legal services" means any services normally provided by or at the direction of an attorney.

3. "Participant" means an individual who is enrolled in a prepaid legal services plan.

4. "Prepaid legal services organization" means any person who undertakes to provide an arrangement for one or more legal service plans.

5. "Prepaid legal services plan" means any arrangement whereby any person undertakes to provide, arrange for, pay for, reimburse or indemnify on a prepaid basis all or part of the cost of legal services and related expenses and court costs incurred in the exercise of any legal right, but not including payment of fines, penalties, judgments, or assessments.

6. "Provider" means any attorney licensed or otherwise authorized to practice law in this state.

26.1-19-03. Exceptions. This chapter does not apply to:

1. Commercial insurers licensed or authorized to do business in this state or to any nonadmitted insurers.

2. Retainer contracts made by attorneys with individual clients with fees based upon an estimate of the nature and

amount of services to be provided to a specific client and similar contracts made with a group of clients involved in the same or closely related legal matters.

3. Plans providing no benefits other than consultation with and advice by an attorney in connection or combination with referral services.

4. The furnishing of legal services on an informal basis, involving neither an express contractual obligation nor reasonable expectations, in the context of an employment, membership, educational, or similar relationship.

5. Employee welfare benefit plans as defined by the Employees Retirement Income Security Act of 1974 [Pub. L. 93-406; 88 Stat. 829].

26.1-19-04. Establishment of a prepaid legal services organization.

1. Notwithstanding any law of this state to the contrary, any person may apply to the commissioner for and obtain a certificate of authority to establish and operate a prepaid legal services organization in compliance with this chapter. A person may not establish or operate a prepaid legal services organization in this state, or sell, offer to sell, or solicit offers to purchase or receive advance or periodic considerations in conjunction with a prepaid legal services plan without obtaining a certificate of authority under this chapter. A foreign corporation may similarly apply for a certificate of authority under this chapter, subject to its registration to do business in this state as a foreign corporation under chapter 10-22.

2. Every prepaid legal services organization as of July 1, 1981, must submit an application for a certificate of authority under subsection 3. The applicant may continue to operate until the commissioner acts upon the application. If the application is denied under section 26.1-19-06, the applicant must be treated as a prepaid legal services organization whose certificate of authority has been revoked.

3. The application for a certificate of authority must be made in a form prescribed by the commissioner and be verified by an officer or authorized representative of the applicant and must set forth or be accompanied by:

   a. A copy of the basic organizational documents of the applicant, if any, including articles of incorporation, partnership agreements, trust agreements, or other applicable documents.

b. A copy of the bylaws, regulations, or similar documents, if any, regulating the conduct of the internal affairs of the applicant.

c. A list of the names, addresses, and official capacities within the organization of all persons who are responsible for the conduct of the affairs of the applicant, including all members of the governing body, the officers and directors in the case of a corporation, the partners under a partnership, the trustees under a trust agreement, and the members or owners under any other organizational form.

d. A statement generally describing the organization, its enrollment process, its administrative operations, any cost and quality control assurance mechanisms, its internal grievance procedure, the method it proposes to use to enroll members, the geographic area or areas to be served, the location of its office or offices, the number of providers to be utilized, and the recordkeeping system which will provide documentation of the utilization of plan benefits by enrolled participants.

e. A power of attorney duly executed by the applicant, if not domiciled in the state, appointing the commissioner and the commissioner's successors in office and duly authorized deputies as the true and lawful attorneys of the applicant in and for this state upon whom all lawful process may be served in any legal action or proceeding against the organization on a cause of action arising in this state.

f. Copies of all contract forms the organization proposes to furnish to enrolled participants.

g. Copies of all contract forms the organization proposes to enter into with providers.

h. Copies of the forms evidencing coverage to be issued to enrolled participants.

i. Copies of the forms of group contracts, if any, which are to be issued to employers, unions, trustees, or other organizations.

j. A statement of the financial condition of the organization, including income statement, balance sheet, and sources of funds.

k. A description of the proposed marketing techniques and copies of any proposed advertising materials.

l. A schedule of rates with any available actuarial and other data.

m. Any other information the commissioner requires to make the determinations required under section 26.1-19-06.

26.1-19-05. State bar association - Advisory committee.

1. Upon receipt of an application for issuance of a certificate of authority, the commissioner shall transmit copies of the application and accompanying documents to the state bar association of North Dakota.

2. An advisory committee to assist the commissioner in the development of rules governing the conduct or organizations authorized under this chapter is created. The committee consists of seven members appointed by the board of governors of the state bar association of North Dakota. Members of the committee are allowed expenses for travel, board, and lodging in the performance of their duties as provided in sections 44-08-04 and 54-06-09. Members of the committee have the right to participate in any hearing held under this chapter, and must receive notice of any order or decision of the commissioner.

26.1-19-06. Issuance of a certificate of authority. The commissioner shall issue a certificate of authority to any person filing an application within sixty days after the filing unless the commissioner notifies the applicant during that time that the application is not complete or sufficient and the reasons therefor, that payment of the fees required by section 26.1-19-15 has not been made, or that the commissioner is not satisfied that:

1. The basic organizational documents of the applicant, when combined with the powers enumerated in section 26.1-19-07, permit the applicant to conduct business as a legal services organization.

2. The organization has demonstrated the intent and ability to provide the services in a manner which insures their availability and accessibility.

3. The organization is financially responsible and may be reasonably expected to meet its obligations to its enrolled participants. In making this determination the commissioner shall consider:

   a. Any agreement with an insurer or any other organization paying, contracting to pay for or in any way guaranteeing the provision of legal services under the plan.

b. Any agreement with the providers for the furnishing of legal services under the plan.

c. The adequacy of working capital.

d. Any surety bond or deposit of cash or securities as a guaranty that plan services will be performed.

26.1-19-07. Powers of organization. The powers of a holder of a certificate of authority issued pursuant to section 26.1-19-04, in addition to any other powers conferred by law, include the following:

1. The purchase, lease, construction, renovation, operation, or maintenance of facilities and property reasonably required for the delivery of services or for such purposes as may be reasonably necessary to the operation of the organization.

2. The furnishing of legal services on a prepaid basis under agreements of indemnity with plan enrollees or under service contracts with providers who are under contract with, employed by, or otherwise associated with the prepaid legal services organization.

3. The marketing and administration of prepaid legal services plans, or contracting with any person for the performance of these functions on its behalf.

4. Contracting with an insurance company licensed or authorized to do business in this state for the provision of insurance, indemnity, or reimbursement against the cost of legal services provided by a prepaid legal services organization.

26.1-19-08. Contract forms.

1. All contracts or other documents evidencing coverage issued by the prepaid legal services organization to participants and marketing documents purporting to describe the organization's prepaid legal services plan must contain:

   a. A complete description of the legal services to which the participant is entitled.

   b. The predetermined periodic rate of payment for legal services, if any, which the participant is obligated to pay.

   c. All exclusions and limitations on services to be provided including any deductible or copayment feature and all restrictions relating to preexisting conditions.

d. All criteria by which a participant may be disenrolled or denied reenrollment.

2. A contract between a legal services organization authorized to do business under this chapter and any provider or any participant may not contain any provisions which require participants to guaranty payment, other than copayments and deductibles, to the provider in the event of nonpayment by the legal services organization for any covered services which have been performed under contracts between the participant and the legal services organization.

3. A contract form or amendment may not be issued unless it is approved by the commissioner. The contract form or amendment is deemed approved thirty-one days after its filing with the commissioner unless the commissioner finds during this period that the contract form or amendment does not comply with the requirements of section 26.1-19-06 or subsection 1 of this section.

26.1-19-09. Control prohibited. A prepaid legal services organization may not attempt to control any attorney in the exercise of the attorney's professional judgment.

26.1-19-10. Licensing of sales representatives. The sales representatives of a prepaid legal services organization are subject to the laws pertaining to insurance agents as defined in chapter 26-17.1. The license or certification for the sales representatives must be issued on a form prescribed by the commissioner, and the fee therefor is three dollars.

26.1-19-11. Prohibited practices.

1. A prepaid legal services organization, or representative thereof, may not cause or knowingly permit the use of advertising, solicitation, or any form of coverage which is false, fraudulent, misleading, or deceptive. For the purposes of this section:

   a. A statement or item of information is false if it does not conform to fact in any respect which is or may be significant to a participant, or a person considering participating in a legal service plan.

   b. A statement or item of information is misleading, whether or not it may be literally untrue, if, in the context in which the statement is made or the item of information is communicated, the statement or item of information may be reasonably understood by a reasonable person, not possessing special knowledge regarding legal services coverage, as indicating any benefit or advantage or the absence of any exclusion, limitation, or disadvantage of possible significance

to a participant, or person considering participating in a legal services plan, if that benefit or advantage or absence of limitation, exclusion, or disadvantage does not in fact exist.

c. An evidence of coverage is deceptive if the evidence of coverage taken as a whole and with consideration given to typography and format and language is such as to cause a reasonable person, not possessing special knowledge regarding legal services plans and evidence of coverage thereof, to expect benefits, services, or changes which the evidence of coverage does not provide or which the legal services plan issuing such evidence of coverage does not regularly make available for participants covered under the evidence of coverage.

2. A participant's coverage may not be canceled or nonrenewed except for the failure to pay the charge for that coverage, or for other reasons as may be set out in a rule adopted by the commissioner.

3. A prepaid legal services organization may not use in its name, contracts, or literature, the words "insurance", "casualty", "surety", or "mutual", or any other words descriptive of the insurance, casualty, or surety business or similar to the name or description of any insurance or surety corporation doing business in this state.

26.1-19-12. Complaint system.

1. A prepaid legal services organization must establish and maintain a complaint system which has been approved by the commissioner to provide reasonable procedures for the resolution of complaints initiated by participants concerning any aspect of the prepaid legal services plans operated by the organization.

2. A prepaid legal services organization must submit to the commissioner an annual report in a form prescribed by the commissioner which must include:

   a. A description of the procedure used under the complaint system.

   b. The total number of complaints by type handled through the complaint system.

   c. The disposition of all complaints filed under the system.

3. A prepaid legal services organization must maintain records of complaints, must retain those records for a period of three years, and must make those records

available for inspection by the commissioner; provided, however, that no information regarding a participant or an attorney considered protected by the confidential nature of the attorney-client relationship may be divulged without written consent of the participant or upon appropriate court order.

4. Complaints alleging misfeasance, malfeasance, or nonfeasance on the part of the attorneys or complaints alleging violations of the code of professional responsibility must be submitted to the disciplinary board of the supreme court for disposition.

26.1-19-13. Reports to the commissioner. Every prepaid legal services organization must annually, on or before March first, file a report with the commissioner, verified by an appropriate official of the organization, showing its financial condition on the last day of the preceding calendar or fiscal year. The report must include:

1. A financial statement of the organization, including its balance sheet and statement of income and expenditures for the preceding year prepared by an independent certified public accountant.

2. Any changes in the information submitted initially upon application for a certificate of authority under section 26.1-19-04.

3. Any other information relating to the performance of the organization which the commissioner may require to carry out the commissioner's duties under this chapter.

26.1-19-14. Examinations.

1. The commissioner shall make an examination of the operations of any prepaid legal services organization holding a certificate of authority under this chapter. The examination must include all contracts, agreements, and arrangements for the delivery of services under the plan as often as the commissioner deems necessary, but not less frequently than once every three years.

2. The commissioner shall make an examination concerning the delivery of legal services of any prepaid legal services organization by reviewing any complaints made by participants brought against the organization or against providers with whom the organization has contracts or other agreements as often as the commissioner deems necessary but not less frequently than once every three years.

3. Every prepaid legal services organization must make its books and records relating to its operations available to the commissioner to facilitate the examination.

4. The commissioner may not undertake an examination which would violate the attorney-client privilege except with the written consent of the participant.

5. For the purpose of examination, the commissioner may issue subpoenas, administer oaths to, and examine the officers and agents of the prepaid legal services organization, as well as any providers of services.

26.1-19-15. Fees. A prepaid legal services organization must pay to the commissioner:

1. For filing a copy of its application for a certificate of authority or amendment thereto, the amount provided by section 26.1-01-07.

2. For filing an annual report, the amount provided by section 26.1-01-07.

3. The expenses of any examinations conducted pursuant to section 26.1-19-14.

26.1-19-16. Administrative findings and sanctions.

1. The commissioner, consistent with chapter 28-32, may initiate proceedings to determine if a prepaid legal service organization has:

   a. Operated in a manner that materially violates its organizational documents;

   b. Materially breached its obligations to furnish the legal services specified in its contracts with enrolled participants;

   c. Violated this chapter, or any rule adopted under this chapter;

   d. Made any false statement with respect to any report or statement required by this chapter or by the commissioner under this chapter;

   e. Advertised, marketed, or attempted to market its services in a manner which misrepresents its services or its capacity to deliver services, or engaged in deceptive, misleading, or unfair practices with respect to advertising or marketing; or

   f. Attempted to prevent the commissioner from the performance of any duty imposed by this chapter or by other laws of this state.

2. After providing written notice and an opportunity for a hearing pursuant to chapter 28-32, the commissioner shall make administrative findings and, as appropriate, may:

   a. Impose a penalty of not more than five thousand dollars for each unlawful act committed under this chapter;

   b. Issue an administrative order requiring the prepaid legal services organization to cease or modify inappropriate conduct or practices by it or any of the personnel employed by or associated with it, to fulfill its contractual obligations, to provide a service which has been improperly denied, or to take steps to provide or arrange for any services which it has agreed to make available; or

   c. Suspend or revoke the certificate of authority of the prepaid legal services organization.

3. If its certificate of authority is suspended, the prepaid legal services organization may not, during the period of suspension, enroll any additional participants and may not engage in any advertising or solicitation.

4. If its certificate of authority is revoked, the prepaid legal services organization must proceed under the supervision of the commissioner, immediately following the effective date of the revocation, to wind up its affairs, and may conduct no further business except as may be essential to the orderly conclusion of those affairs. The commissioner, by written order, may permit further operation of the organization if it is in the best interest of the participants and will allow the participants the greatest practical opportunity to obtain continued legal services coverage.

5. The commissioner may apply to any court for the legal or equitable relief deemed necessary to carry out the purposes of this chapter.

26.1-19-17. Statutory construction and relationship to other laws. Except as otherwise provided in this chapter, other provisions of the insurance laws of this state are not applicable to any legal services organization issued a certificate of authority under this chapter.

26.1-19-18. Rulemaking authority of commissioner. The commissioner may adopt reasonable rules necessary and proper to carry out this chapter. This chapter does not prohibit the commissioner from requiring changes in procedure previously approved.

SECTION 20. Chapter 26.1-20 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-20-01. Title insurance company subject to insurance company requirements. Every domestic or foreign corporation organized for the purpose of insuring titles to real property in this state or of insuring against loss by reason of defective titles thereto, or encumbrances thereon, is subject to and must comply with all the requirements of the laws of this state made applicable to insurance companies generally and the rules of the commissioner, except as provided in this chapter or where the laws and rules are inconsistent with this chapter.

26.1-20-02. Capital stock and surplus requirement. A domestic corporation organized for the purpose of insuring titles to real property in this state or of insuring against loss by reason of defective titles to real property, or encumbrances on real property, may not be incorporated unless it has an authorized capital of not less than five hundred thousand dollars and a surplus of not less than five hundred thousand dollars if a stock company, and a surplus of not less than five hundred thousand dollars if a mutual company. If the capital or surplus requirements at the time the company was incorporated under this chapter were less than the minimum requirements provided by this section, the company may maintain authorized capital or surplus which satisfies the capital stock or surplus requirements in effect at that time. It may issue no policy or insurance until at least fifty percent of the minimum capital stock required by this section, and all the surplus required, have been paid in, the residue of capital stock to be paid in within twelve months from the time of filing the articles of incorporation, but the commissioner, for good cause shown, may extend the time of payment of the residue for the further period of one year.

26.1-20-03. Surplus to constitute guaranty fund - Deposit. The surplus provided for in section 26.1-20-02 constitutes a guaranty fund, which must be invested in securities as provided by section 26.1-05-19, and be duly deposited with the commissioner, and the commissioner's certification of that deposit must be procured, as provided by law. This deposit must be maintained unimpaired and the principal of the fund may be applied only to the payment of losses and expenses by reason of its guaranty and insurance contracts, but the corporation has the right to collect the income from the deposit and to substitute other like securities of equal amount and value from time to time.

26.1-20-04. Limitation on risks. A title insurance company transacting business in this state may not expose itself to loss on any one risk or hazard to an amount exceeding fifty percent of its paid-up capital and surplus if a stock company, or fifty percent of its surplus if a mutual company, unless the excess is reinsured.

26.1-20-05. Title evidence - Examination. A domestic corporation organized for the purpose of insuring title to real property in this state or of insuring against loss by reason of defective titles to real property, or encumbrances on real property, or a foreign corporation authorized to do business in this state, may not issue any policy, binder, or certificate unless it has secured from a

person, firm, or corporation holding a certificate of authority under chapter 43-01 the record title evidence of the title to be insured, and the title evidence has been examined by a person duly admitted to the practice of law as provided by chapter 27-11. The certificate of authority of any corporation violating this section must be revoked as provided by chapter 26.1-02 or 26.1-11.

26.1-20-06. Judgment against corporation - Enforcement. If a corporation fails to satisfy any judgment against it arising out of its liability under any title insurance policy, issued, insured, or assumed by it, within thirty days after the finality of the judgment becomes fixed, the judgment may be enforced against its guaranty fund deposit through the following procedure:

1. The judgment creditor shall petition the court wherein the judgment is entered and as part of the same cause, truthfully setting forth the facts regarding the failure to satisfy the judgment as required by this section.

2. Upon the petition the court must direct the issuance of a special execution directed to the sheriff of Burleigh County, requiring that the sheriff sell so much of the securities on deposit as may be required to satisfy the judgment and pay the costs of the levy.

3. The special execution must be executed by the sheriff by delivering to the state treasurer and to the commissioner a certified copy of the writ of execution together with a certified copy of the judgment and of the petition and order, and within ten days thereafter there shall be delivered to the sheriff sufficient securities to satisfy the judgment in full. The sheriff shall sell the securities upon execution as in the case of sales of personal property upon execution generally.

SECTION 21. Chapter 26.1-21 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-21-01. Definitions. In this chapter, unless the context or subject matter otherwise requires:

1. "Blanket bond" means a bond which covers collectively all public employees and public officials without the necessity of scheduling names or positions as a part of the bond, and a bond whereby new public employees and new public officials entering employment or office during the period of the bond are automatically included without notice to the fund.

2. "Fund" means the state bonding fund.

3. "Political subdivision" means a county, city, township, school district, or park district, or any other unit of local government of this state.

4. "Public employee" means any person employed by the state or a political subdivision, except for a person employed by an occupational and professional board or commission under title 43 or by the state bar association.

5. "Public official" means any officer or deputy, either elected or appointed, of the state or a political subdivision who is required to be bonded by any law of this state, except for an officer of an occupational and professional board or commission under title 43 or of the state bar association.

6. "State" means state departments, agencies, industries, and institutions.

26.1-21-02. State bonding fund under management of commissioner. The commissioner shall manage the fund. The fund shall be maintained as a fund for the bonding of public employees including those who are not specifically required by law to be bonded. All moneys collected under this chapter shall be paid into the fund.

26.1-21-03. Commissioner may employ assistants. The commissioner may employ any clerical and other assistants necessary to operate the fund. The salaries of all employees together with all other expenditures for the operation of the fund shall remain within the legislative appropriations for such purposes and shall be paid by warrant-check drawn on the state treasury prepared by the office of management and budget after the approval of expense vouchers by the office of the budget.

26.1-21-04. Attorney general is attorney for fund. The attorney general shall act as attorney for the commissioner in every action and proceeding to which the commissioner is a party on behalf of the fund.

26.1-21-05. Investment of fund. Investment of the fund is under the supervision of the state investment board in accordance with chapter 21-10.

26.1-21-06. Blanket bond coverage available to state and political subdivisions. The fund shall provide coverage as set forth in section 26.1-21-12 in the form of a blanket bond to state departments, agencies, industries, and institutions, and to political subdivisions, subject to the approval of the commissioner who may exclude certain public employees or groups of public employees. The commissioner shall prescribe the kind of blanket bond coverage, with or without deductible provisions, available through the fund, the procedure to be followed in obtaining blanket bond coverage, and the forms for requesting blanket bond coverage. Public officials required to be bonded by law may be included in the blanket bond coverage, and the blanket bond coverage may be greater but not less than the largest stated bond amount as provided in the law for the positions. The blanket bond fulfills statutory bonding requirements for any position of a public official.

26.1-21-07. Review of public official and public employee bond coverage. Each state agency, department, industry, and institution shall annually review the amount of blanket bond coverage of its officers and employees. The amount for which the officials and employees shall be bonded shall be based upon the amount of money or property handled and the opportunity for defalcation. As provided in section 26.1-21-06, blanket bond coverage may be greater than but not less than the amount provided for such positions in other statutes.

When conducting an audit examination of state agencies, departments, industries, and institutions, the state auditor shall evaluate the blanket bond coverage and, if deemed necessary, shall include recommendations for changes in the amount of that coverage in the auditor's report.

26.1-21-08. Report of election or appointment of public official - Payment of premiums. Before any public official, excluding one whose position is covered by a blanket bond, may assume one's duties, the state auditor, county auditor, city auditor, township clerk, or school district clerk, as the case may be, shall report to the commissioner in the manner and form prescribed by the commissioner, the election or appointment of the public official and the amount of the bond required, and shall remit with the report by check, draft, or express or postal money order the premium required under this chapter.

26.1-21-09. Automatic insurance of state and political subdivisions. The public employees and public officials of the state and each political subdivision, as the case may be, shall be insured in the fund according to this chapter upon application to the fund and upon approval by the commissioner. Unless an application is denied within sixty days from the date it is received by the fund, the application is deemed approved and bond coverage in force. The provisions of this chapter and of any statute requiring a bond constitute the bond of the public official for the purpose of any law of this state requiring the bond and constitute the entire contract between the fund and the state or political subdivisions, respectively, as the obligee on the bond.

26.1-21-10. Premiums - Amount - Payment - Minimum. The premium for insurance furnished under this chapter, not including the premium for a blanket bond which shall be determined by the commissioner, is twenty-five cents per year per one hundred dollars of the amount of the required bond. Premiums shall be paid in advance by the proper authority of the state or of the political subdivision which the public official for whom a bond is required was elected or appointed to serve, from its treasury, to the state treasurer who shall deposit the premiums in the fund. The state treasurer shall issue quadruple receipts therefor. The state treasurer shall file one receipt in the treasurer's office, and shall mail one to the official making the payment, one to the commissioner, and one to the state auditor. The minimum premium for each bond is two dollars and fifty cents per year. Unless the term of office or employment is for a shorter period, payments shall be

made for one year or for any longer term prescribed by the commissioner. The bonds of all retiring public officials shall be transferred to their successors for unexpired terms without any additional premium, when written application is made to the commissioner. No notice or application is required when a public official is covered under a blanket bond. All premiums are waived whenever the reserve of the fund reaches three million dollars. The collection of premiums shall be resumed whenever the reserve is depleted below two and one-half million dollars.

26.1-21-11. Effect of failure to report election or appointment of public official or follow procedure prescribed by commissioner or to pay bond premium - Penalty. Unless the report required by section 26.1-21-08 is made in the case of an individual bond or the procedure prescribed by the commissioner is followed in the case of a blanket bond and the premium required by section 26.1-21-10 is paid within ten days after the service of a public official has begun, the officer whose duty it is to make the report or follow the procedure and pay the premium, during the term of the default, is liable as a surety on the bond of the public official with the same effect and to the same extent as if the bond had been signed, approved, and filed as otherwise required by law. In addition, any officer guilty of this default is guilty of a class A misdemeanor. No compensation may be paid to any public official unless the official's appointment or election is reported or the procedure prescribed by the commissioner is followed, as the case may be, and the premium payment for the public official's bond or blanket bond is made to the commissioner or a bond has been filed in lieu thereof as provided in this chapter.

26.1-21-12. Condition of bond created by chapter - Limitation. The condition of any bond arising under this chapter is limited to that of a surety or fidelity bond and provides that the public employee or public official, as principal, shall render a true account of all moneys and property of every kind that come to the person as a public employee or public official, and shall pay over and deliver the same according to law.

26.1-21-13. Default of public employee or public official - Duty of public officer - Limitation on filing of claims against fund. Within sixty days after the discovery of any default or wrongful act on the part of any public employee or public official, for which the fund is or may become liable, the state auditor, county auditor, city auditor, township clerk, or school district clerk, or the treasurer of the state or political subdivision if the defaulting officer is the auditor or clerk of the state or political subdivision, and any other officer having supervision of a defaulting public employee or public official, shall file a claim with the commissioner against the fund. Any person injured by the default or wrongful act, if that person intends to hold the fund liable, must present the claim to the commissioner within sixty days after the discovery of the default or wrongful act. If a claim is not filed within the time required by this section, the claim is waived. A claim filed under this section must contain an abstract of the facts upon which it is

based and must be verified by the claimant or by someone in the claimant's behalf, and, together with all papers relating thereto, shall remain on file with the commissioner.

26.1-21-14. Commissioner to notify state auditor of default of public employee or public official - Duty of state auditor. If any public employee or public official defaults or creates a liability against the fund, the commissioner shall notify the state auditor, who immediately shall check the accounts of that public employee or public official and file a report with the commissioner stating the amount, if any, due from the fund because of the default or wrongful act. For this service, the auditor shall be paid out of the fund the same fees as the auditor is paid for auditing the accounts of county officers.

26.1-21-15. Audit of claims against fund - Register of claims. The commissioner shall audit all liability claims against the fund, and the attorney general shall approve the audit. The commissioner may prescribe the forms upon which claims must be presented, and may administer oaths and examine witnesses in connection with the claims. If the commissioner, with the approval of the attorney general, finds a claim or any part thereof to be a valid, just, and proper charge against the fund, the commissioner shall make and file an order to that effect and state therein the amount allowed upon the claim. The commissioner shall enter a brief description of every claim filed against the fund in a register provided for that purpose showing the name of the claimant, the amount and character of the claim, the action taken upon the claim, and the date when the action was taken.

26.1-21-16. Filing claim is condition precedent to bringing action - Failure to act is refusal. An action may not be maintained against the fund upon any claim whatever until the claim first has been presented for allowance as provided in this chapter and the allowance has been refused. Any claim which has not been acted upon and allowed or disallowed within sixty days after its presentation for allowance is deemed to be refused. The filing and disallowance of the claim must be alleged in the complaint in any action brought thereon against the fund.

26.1-21-17. Limitation of time for bringing action against the fund. An action may not be maintained against the fund upon any claim whatever unless the action is commenced within one year after the filing of the claim with the commissioner.

26.1-21-18. Suit by party injured by default of public employee or public official - Subrogation - Right of appeal. Any person or corporation injured by the default or wrongful act of any public employee or public official may sue the public employee or public official and to effect recovery from the fund must join the fund as codefendant. A judgment must be obtained against the public employee or public official to create liability upon the bond. If a judgment is obtained against the public employee or public official, it must specify that, to the extent to which the fund is liable upon the bond of the public employee or public official, the judgment shall

be paid out of any moneys in the fund or that may accrue to the fund. If a judgment is paid out of the fund, the fund has a right to recover and is subrogated to the right of the judgment creditor to recover against the public employee or public official. In all proceedings to enforce the right of subrogation, the commissioner shall act for and in behalf of the fund, and in any action or proceeding, the commissioner may appeal from any appealable order or from any judgment against the fund the same as other parties to civil actions may appeal.

26.1-21-19. Allowed liability claims payable from fund - Administrative expenses - Methods of payment. All liability claims which are allowed against the fund shall be paid upon warrants drawn upon the state treasurer against the fund. The office of management and budget shall prepare the warrants pursuant to the directions of the commissioner. Payments for administrative expenses of the fund shall be made within the limitations of legislative appropriations upon warrant-checks prepared by the office of management and budget after the approval of vouchers by the commissioner.

26.1-21-20. Commissioner may make examinations - Request for accounting - Reporting defaulting public official to governor. If the commissioner is of the opinion that the interests of the fund are jeopardized by the misconduct or inefficiency of any public official, the commissioner shall make, or request the state auditor to make, an examination, and, if necessary, shall cause an action for an accounting to be instituted against the public official for the purpose of requiring a complete disclosure of the business of the office of which the public official is an incumbent. The action shall be brought in the name of the commissioner as plaintiff, and the court in the action may interplead all parties concerned. Whenever the commissioner deems it advisable, the commissioner shall make a complaint to the governor requesting the governor to institute an investigation with the purpose of removing from office any defaulting public official or any public official who conducts the affairs of office so as to endanger the fund.

26.1-21-21. Cancellation of liability of fund - Effect. The commissioner, after due investigation and if in the commissioner's judgment the interests of the fund require, may cancel the liability of the fund for the acts of any public employee or public official. The cancellation shall take effect thirty days after written notice thereof. The public official whose bond is canceled, or the public employee whose coverage is canceled under a blanket bond, may secure, at one's own expense, a bond executed by a duly authorized surety company.

26.1-21-22. Notice of cancellation - Right to appeal from cancellation - Procedure. The commissioner shall notify the public employee or public official immediately by registered mail when one's bond, or coverage under a blanket bond, is ordered canceled, and the public employee or public official has twenty days after the receipt of notice to take an appeal from the decision of the commissioner to the district court of the judicial district in which the public

employee or public official resides. The court shall hear the appeal at a day to be fixed by the judge not less than ten days nor more than thirty days after the filing of the appeal with the clerk. The appellant shall serve notice of appeal upon the commissioner. The court shall try the case without a jury.

26.1-21-23. Fund may reinsure risks - Premium on reinsurance. The commissioner may reinsure any part of any liability in excess of twenty-five thousand dollars upon any one public official, or group of public officials and public employees under a blanket bond, at a cost not exceeding the rate of premium provided for in this chapter, and the expense of the reinsurance shall be paid out of the fund.

26.1-21-24. Publication of statement of fund - Biennial report. The commissioner, on or about the first day of December in each odd-numbered year, shall publish in four newspapers of general circulation within the state a copy of the statement of the commissioner's work and of the condition of the fund during the two preceding fiscal years. The commissioner shall submit a biennial report as prescribed by section 54-06-04.

26.1-21-25. Public official may furnish private bond - Payment of premium for private bond. Any person elected or appointed to office, in lieu of the bond provided for in this chapter, may furnish a bond issued by a duly authorized surety company, but no officer or board of the state or of any political subdivision may pay for the bond out of public funds, except for a bond procured to cover an excess over the amount carried in the fund.

SECTION 22. Chapter 26.1-22 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-22-01. Definitions. In this chapter, unless the context or subject matter otherwise requires:

1. "Fund" means the state fire and tornado fund.

2. "Permanent contents" refers only to such public property usually kept or used in or about public buildings insured in the fund, and to all public personal property usually kept or used in or about all buildings used for public purposes, or within one hundred feet [30.48 meters] of all such buildings, or while on sidewalks, streets, alleys, yards, detached platforms, and in or on railway cars. Permanent contents does not include automobiles, trucks, tractors, road machinery, or similar property used principally outside of such buildings.

3. "Political subdivision" includes a county, city, township, school district, or park district of this state.

26.1-22-02. State fire and tornado fund under management of commissioner. The commissioner shall manage the fund. The fund shall be maintained as a fund to insure the various state industries and

the various political subdivisions against loss to the public buildings and fixtures and permanent contents therein, through fire, lightning, inherent explosion, windstorm, cyclone, and tornado and hail, explosion, riot attending a strike, aircraft, smoke, vehicles, and at the option of the insured the fund shall have the authority to insure against any other risks of direct physical loss. All moneys collected under this chapter shall be paid into the fund for use only for the purposes provided for in this chapter.

26.1-22-03. Employment of assistants - Expenditures from fund. To carry out this chapter, the commissioner may utilize any information on file in the state fire marshal department and any of the employees of the commissioner, and the commissioner may employ necessary assistants and incur necessary expenses. All expenditures made for these purposes shall remain within the limits of legislative appropriations and shall be paid out of the fund upon warrants prepared by the office of management and budget drawn upon the state treasurer after the approval of vouchers by the office of the budget.

26.1-22-04. Investment of fund. Investment of the fund is under the supervision of the state investment board in accordance with chapter 21-10.

26.1-22-05. Public buildings insurable only in fund. The public buildings and fixtures and permanent contents therein belonging to the state, the various state industries, and the political subdivisions, shall be insured under this chapter. No officer or agent of the state or of any political subdivision, and no person having charge of any public buildings belonging to the state, any state industry, or any political subdivision, may pay out any public moneys or funds on account of any insurance against loss by fire, lightning, inherent explosion, windstorm, cyclone, tornado and hail, explosion, riot attending a strike, aircraft, smoke, vehicles, or any other risks of direct physical loss, or contract in any manner for, or incur any indebtedness against, the state or any political subdivision on account of any such insurance upon any of the buildings or fixtures and permanent contents therein belonging to the state or any political subdivision, except in the manner provided in this chapter.

26.1-22-06. Commissioner to adopt guidelines on insurable values for state-owned property. The commissioner shall adopt guidelines to be used by state agencies, departments, offices, officers, boards, and commissions for the purpose of determining insurable values of state-owned property for insurance coverage as authorized by law.

26.1-22-07. Certain property of state and of Bank of North Dakota excepted. This chapter does not apply to farm buildings situated on land owned by the state, nor to the property of the Bank of North Dakota other than its banking house, furniture, and fixtures located in the city of Bismarck.

26.1-22-08. Townships and school districts have option as to insurance on certain property. This chapter does not apply to the property of any township or school district located outside of the incorporated limits of a city unless the clerk of the township or school district, at the direction of the board of township supervisors or the school board, files with the commissioner a written application for insurance and a request that the township or school district come under this chapter. To be effective, the application must be approved in writing by the commissioner.

26.1-22-09. Public buildings to be reported to commissioner. In each odd-numbered year, or upon application for insurance, the state board of higher education, and each officer, department, or agent of the state and of any industry thereof having in charge any public building belonging to the state, and each county auditor, city auditor, township clerk, and school district clerk, as the case may be, shall report to the commissioner the insurable value of each public building, with the exception of buildings insured by private insurance companies, and of the fixtures and permanent contents therein, with the exception of fixtures and permanent contents insured by private insurance companies, belonging to the state or political subdivision, and shall supply such other information as may be required by the commissioner on forms provided by the commissioner.

26.1-22-10. Commissioner to provide insurance on all public buildings. Upon application the commissioner shall provide for insurance against loss by fire, lightning, inherent explosion, windstorm, cyclone, tornado and hail, explosions, riot attending a strike, aircraft, smoke, vehicles, or any other risks of direct physical loss, all in the manner and subject to the restrictions of the standard fire insurance policy and standard endorsement, and no other hazards, in the fund, on all buildings owned by the state, state industries, and political subdivisions, and the fixtures and permanent contents in such buildings, to the extent of not to exceed the insurable value of such property, as the value is determined by the commissioner and approved by the officer or board having control of such property, or, in case of disagreement, by approval through arbitration.

All public buildings owned by a political subdivision, in lieu of coverage provided for in this section, may at the option of the governing body of the political subdivision be insured on the basis of competitive sealed bids, through the fund which shall be invited to submit a sealed bid or private insurance companies licensed to do business in this state, against damage resulting from hazards, which include those types of hazards that may be insured against by the fund. The governing body may reject any or all such bids.

All public libraries owned by the state or political subdivisions may, in addition to the coverage provided for in this section, be covered against damage through vandalism. If this coverage cannot be extended to the public libraries situated within this state, the libraries may contract for this coverage with

private insurance companies; provided, that this coverage meets the recommendations of the insurance code of the American library association.

26.1-22-11. Arbitration. In case the commissioner and the board or officer having charge of any property are unable to agree upon the insurable value of the property, the value shall be determined by a recognized appraisal company at the expense of the state industry or political subdivision owning the property, if the appraisal company arbitrator meets with the approval of both the commissioner and the board or officer concerned. If they are unable to agree on an arbitrator, then the matter shall be submitted to arbitration by a board of arbitration selected as provided by this section. The commissioner and the board or officer in charge of the property each shall select one competent, disinterested contractor, architect, experienced appraiser, appraisal company, or one of the members of such board, and the two so chosen shall select a third person of similar qualification. The three arbitrators shall proceed to determine the insurable value of the property, and the decision of the arbitrators, or a majority of them, shall be given in writing to the commissioner and the board or officials concerned and shall be binding upon both parties. Each party to the dispute shall pay the expense and charges of the arbitrator chosen by the party, and the expense and the charges of the third arbitrator shall be borne equally by both parties to the dispute. The decision by the board of arbitration must be made within thirty days from the time the matter is submitted to it. Until the commissioner and board or officer in charge shall have agreed, or in case of dispute, until the decision of the appraisal company or arbitrators, the property shall continue to be valued in the same amount as previously, or in case of new buildings or property, in the amount fixed by the commissioner. The same procedure shall be followed in case of new construction or in any increase or decrease in values.

26.1-22-12. Policy fee. For each insurance policy issued, the commissioner shall collect a fee of ten cents per thousand dollars, but the fee may not be less than two dollars.

26.1-22-13. Reserve balance - Payment of loss. All assessments, interest, and profits on investments and all other income of the fund shall be added to a reserve balance within the fund. All losses incurred and operating expenses appropriated by the legislative assembly shall be paid from the reserve balance in the manner provided by law.

26.1-22-14. Assessments and reporting of premiums and losses. If the reserve balance is less than twelve million dollars, the commissioner shall determine the amount of money necessary to bring the reserve balance up to twelve million dollars and the commissioner shall then levy an assessment against every policy in force with the fund on all public property. The assessment shall be computed as follows:

The eighty percent or ninety percent coinsurance rate established by the insurance services office for each insured property to which the eighty percent or ninety percent coinsurance rate may be applicable, and the full rate established for properties to which the eighty percent or ninety percent coinsurance rate is not applicable under the rules of the insurance services office, shall be applied to the amount of insurance provided in each policy and the result of the application of the rate to the amount of insurance shall set the tentative assessment to be made against the policy. The total of all tentative assessments shall then be ascertained. The percentage of the assessment necessary to restore the reserve balance to the sum of twelve million dollars shall then be computed and collected on each policy; provided, that until the reserve balance shall reach twelve million dollars, the assessment shall be in an amount determined by the commissioner but in no event in excess of sixty percent of the rates set by the insurance services office unless the reserve balance is depleted below three million dollars. In case of a fractional percentage the next higher whole percent shall be used in such computation.

The commissioner shall submit not later than December thirty-first of each odd-numbered year, all data concerning premiums written and losses incurred during the previous biennium ending July thirty-first to the insurance services office so that the experience of the fund may be included in the computation of rates to apply to the classes of business written by the fund.

26.1-22-15. Collection of premiums and assessments. The commissioner, as soon as possible after providing for the insurance of any property belonging to the state or a political subdivision, shall certify to the board or officer in charge of the property the amount of premium or assessment due from the state, state industry, or political subdivision. The certificate must give the name, location, and description of the property insured, the amount of insurance written thereon, and the amount of the premium or assessment. The proper officer shall remit to the commissioner the amount of the premium or assessment within sixty days after the date of the certification. The commissioner shall deposit the premiums and assessments with the state treasurer to the credit of the fund. If the premiums or assessments are not paid within sixty days after the date on which they are certified, they shall bear interest at the rate of six percent per annum and collection thereof may be enforced by appropriate action. The attorney general and the state's attorney of the several counties shall bring appropriate actions to enforce the collections of the premium and assessment upon request of the commissioner. Payment of the premiums or assessments certified pursuant to this section may be made by any state department, officer, board, institution, or agency and by any political subdivision, out of any available funds, notwithstanding that no specific appropriation or tax levy has been made therefor.

26.1-22-16. Rejection of certain risks. If the commissioner finds that any risk is unreasonably hazardous, the commissioner may require the board or officer having control of the risk to make any improvements or changes necessary to remove the extra hazard. If the board or agency fails to make the improvements or changes within six months after the demand by the commissioner, the commissioner may cancel the insurance on the renewal upon thirty days' notice. No cancellation may be made by the commissioner without the approval of the industrial commission. If a dispute arises between the commissioner and the board or official having control of the risk, either as to the insurability thereof or as to the compliance by the board or officer with the requirements of the commissioner, the dispute shall be submitted to a board of arbitration as provided in section 26.1-22-11 and the decision of the board of arbitration is binding on both parties. If the insurance on any risk is canceled as provided in this section, the board or officer in charge of the risk may procure insurance from any authorized insurance company, and the premium is a proper charge against the state, state industry, or political subdivision owning the property.

26.1-22-17. Loss - How paid. All losses occasioned by the hazards provided for by this chapter shall be paid out of the fund in an amount not exceeding the amount of the insurance upon any particular risk. The loss upon any building or property insured in the fund, whether totally destroyed or partially damaged by reason of the hazards, shall be adjusted by the commissioner or a duly authorized adjuster or adjusting company. Immediately upon the happening or occasion of any such loss or damage, the officer, board, or agency having charge or control of the property destroyed or damaged shall notify the commissioner by telegram or in writing, giving the description of the property, the amount of insurance carried, the probable amount of loss or damage, and the probable cause of loss or damage. The officer, board, or agency having control of the damaged property may not disturb the property except as provided in the policy until the commissioner or the commissioner's agent has adjusted the loss or has given notice that the information on which the adjustment is to be made has been secured. Allowances for loss and damage to insured property shall be paid out of the fund upon warrants drawn by the office of management and budget upon the state treasurer against the fund after the submission of a voucher prepared by the commissioner to the office of management and budget specifying the amount to be paid and the payee to whom the warrants shall be drawn. However, if at any time due to a catastrophe or disaster, or a succession of catastrophes or disasters, the reserve balance has been depleted below two million dollars, the commissioner may, with the approval of the industrial commission, issue premium anticipation certificates in an amount sufficient to bring the reserve balance up to two million dollars. The premium anticipation certificates shall be issued for a period of from ten to twenty years, as determined by the commissioner with the approval of the industrial commission, and the interest and principal shall be paid and retired by assessments levied on all policies in force with the fund. To retire these premium anticipation certificates, the commissioner shall levy a

special assessment against all property insured in the fund; however, the total of all assessments and premiums provided for in section 26.1-22-14 may not exceed the full bureau rate. Any state department may invest its funds in the purchase of the premium anticipation certificates.

26.1-22-18. Arbitration of loss. In case an agreement as to the amount of loss sustained by any building or property insured under this chapter cannot be arrived at between the commissioner or the commissioner's representative and the person or board representing the state or political subdivision owning the building or property, the loss may be arbitrated as provided by law.

26.1-22-19. Repair or replacement of destroyed buildings. If the commissioner and the insured agree that the fund shall repair or replace the building destroyed or damaged, no repairs, rebuilding, or replacement may be undertaken by the commissioner or any employees of the commissioner, but if they are deemed necessary or proper in any case, they shall be performed by independent contractors. The cost of any repairs, rebuilding, or replacements may not exceed the amount of the insurance carried upon the particular risk.

26.1-22-20. Replacement of policies. A policy of insurance in force on August 1, 1943, on property not heretofore required by law to be insured by the fund, may not be canceled by the commissioner, but all such risks, when the policy covering the same lapses, expires, or otherwise is canceled, shall be insured in accordance with this chapter. The amount of the insurance carried by the fund shall be increased or decreased from time to time so as to maintain at all times on the insured property the amount of insurance required by this chapter. All reinsurance policies taken or held by the fund shall be canceled as of August 1, 1943, and all returned premiums thereon shall be added to the reserve fund.

26.1-22-21. Insurance required - Excess loss reinsurance. The commissioner shall procure and shall keep in force, an excess loss reinsurance contract naming the fund as the reinsured. The reinsurance contract shall meet the following minimum specifications:

1. Reimburse the fund for all losses in excess of one million dollars incurred by the fund under policies issued by the fund and arising out of each occurrence of a peril included in the fund policies.

2. The limit of liability of such reinsurance contract shall be no less than one hundred million dollars for each loss occurrence and one hundred million dollars as respects all loss occurrences during each twelve-month period.

3. A sixty-day cancellation notice.

The cost of the excess loss reinsurance shall be paid out of the premium income of the fund. This excess loss reinsurance shall be procured by the commissioner and the fund only through bids as hereinafter provided and shall be written only by a company or companies authorized to do business within this state. The contract shall be negotiated with and countersigned by a licensed North Dakota resident insurance agent. On or before the third Monday in June of each odd-numbered year the commissioner shall publish in the official newspaper of Burleigh County a notice that on the last Monday in June of that year the commissioner will accept bids at the commissioner's office in the state capitol. A copy of the notice shall be posted at the office of the fund. A copy of the notice shall be mailed to each insurance company licensed to write fire insurance in this state. On the last Monday in June of each odd-numbered year, the commissioner, with the approval of the industrial commission, shall contract for the excess loss reinsurance with the company or group of companies submitting the lowest and best bid for the two-year period commencing on the ensuing first day of August. The commissioner, with the approval of the industrial commission, may disregard this section after the commissioner and the commission have studied the available bids for the reinsurance required by this section.

26.1-22-22. Commissioner may waive subrogation rights during construction. The commissioner may, in the commissioner's discretion, waive any right of the fund to recover for damage sustained by any public structure as a result of fire or explosion caused by a contractor, its employees or agents, in the performance of a contract for the alteration of, or the construction of an addition to, a public building insured in the fund.

SECTION 23. Chapter 26.1-23 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-23-01. Unsatisfied judgment fund - Administration of the fund by commissioner - Appropriation. The commissioner shall administer the unsatisfied judgment fund. The commissioner shall perform all duties and responsibilities in regard to the fund not otherwise delegated to the attorney general or the state treasurer under this chapter. Judgments recovered under this chapter shall be paid from moneys deposited in the fund and the moneys are hereby appropriated for such purpose. The expenses arising from administration of the fund shall be paid from the fund within the limits of legislative appropriation.

26.1-23-02. Attorney general - Appointment of counsel. The attorney general shall appoint a special assistant attorney general as legal counsel for the fund pursuant to section 54-12-08 and the special assistant attorney general may perform all the duties and responsibilities in regard to the fund delegated to the attorney general under this chapter. The attorney general at the attorney general's discretion may appoint special counsel to defend the fund. The trial judge of the district court shall fix the amount of the special counsel's fees and expenditures, and certify the amount to

the attorney general who, after approving, shall certify the amount to the commissioner.

26.1-23-03. Additional registration fee - Deposit in fund - Suspension of fee. At the time of registering a motor vehicle, the owner shall pay to the registrar of motor vehicles in addition to the registration fees, a fee of one dollar for each motor vehicle registered. The fees shall be deposited with the state treasurer, who shall credit the fees to the unsatisfied judgment fund. If on June first of any year the amount of uncommitted money in the fund is three hundred thousand dollars or more, the requirement for the payment of the fee is suspended during the succeeding year and until the year in which the fee is reimposed. The fee shall be reimposed for any year whenever on June first of the previous year the uncommitted amount of the fund is less than three hundred thousand dollars.

26.1-23-04. Recovery from fund. Where any person, who is a resident of this state, recovers in any court in this state a judgment for an amount exceeding three hundred dollars in an action for damages resulting from bodily injury to, or the death of, any person occasioned by, or arising out of, the ownership, maintenance, operation, or use of a motor vehicle by the judgment debtor in this state, upon the judgment becoming final, the judgment creditor may, in accordance with this chapter, apply to the judge of the district court in which the judgment was rendered, upon notice to the attorney general, for an order directing payment of the judgment out of the fund. Upon the hearing of the application, the judgment creditor shall show: (1) that the creditor has obtained judgment as set out in this section, stating the amount thereof and the amount owing thereon at the time of the application; (2) that the creditor has caused an execution to be issued thereon, and that (a) the sheriff has made a return thereon showing that no property of the judgment debtor liable to be seized in satisfaction of the judgment debt, could be found, or (b) the amount realized on the sale of property seized, or otherwise realized under the execution, was insufficient to satisfy the judgment, stating the amount so realized and the balance remaining due thereon; (3) that the creditor has caused the judgment debtor, where the debtor is available, to be examined pursuant to law for that purpose, touching the debtor's property, and in particular as to whether the debtor is insured under a policy of automobile insurance against loss occasioned by the debtor's legal liability for bodily injury to, or the death of, another person; (4) that the creditor has made an exhaustive search and inquiry to ascertain whether the judgment debtor is possessed of property, real or personal, liable to be sold or applied in satisfaction of the judgment; and (5) that as a result of the search, inquiry, and examination, the creditor has learned of no property possessed by the judgment debtor and liable to be sold or applied in satisfaction of the judgment debt, or that the creditor has learned of certain property, describing it, owned by the judgment debtor and liable to be seized or applied in satisfaction of the judgment, and has taken all necessary proceedings for the realization thereof, and that the amount thereby realized was

insufficient to satisfy the judgment, stating the amount so realized and the amount remaining due thereon.

26.1-23-05. Recovery from fund when liability cannot be determined. When bodily injury to, or the death of, any person who is a resident of this state is occasioned by or arises out of an accident caused by the operation, maintenance, or use of a motor vehicle in this state and the identity of the person against whom an action might be brought for the recovery of damages for the bodily injury or death resulting from the accident cannot be ascertained, any person who would be entitled to bring the action to recover damages may bring an action in the district court of the county in which the accident occurred within six months from the date of the accident against the unsatisfied judgment fund, by service upon the commissioner and the attorney general, for the recovery of the damages from the fund, provided notice of the accident was given to some police officer immediately after the accident occurred and the name of the officer is alleged in the complaint. A payment may not be made from the fund in satisfaction of any judgment obtained in the action in excess of five thousand dollars, exclusive of costs, for bodily injury to, or the death of, any one person, nor in excess of ten thousand dollars for any one accident.

This section does not limit the liabilities or remedies of any person on the cause of action, growing out of the accident for which suit was brought against the fund, but the fund is subrogated to the rights of any person who has obtained judgment under this section, to the extent that the fund has made payment in satisfaction thereof.

26.1-23-06. Attorney general may appear. Section 26.1-23-04 does not apply in the case of any judgment entered by default, unless the commissioner and the attorney general have been given at least thirty days' notice prior to the entry of judgment, to which notice shall be attached a copy of the summons and complaint. Upon receipt of the notice, the attorney general may enter an appearance, file a defense, appear by counsel at the trial, or take any other action the attorney general deems appropriate on behalf and in the name of the defendant, and may thereupon, on behalf and in the name of the defendant, conduct a defense, and all acts done in accordance therewith shall be deemed to be acts of the defendant. The attorney general may appear and be heard on any application for payment from the fund and may show cause, if any, why the order applied for should not be made.

26.1-23-07. Appeal from order. An order made under section 26.1-23-04 is subject to appeal to the supreme court by the judgment creditor, or by the attorney general, in the manner provided by law for the taking of appeals from final orders in a civil action.

26.1-23-08. Limitation on amount payable from fund - Nonassignable.

1. Recovery from the fund is limited to payment of the following, exclusive of costs:

a. Ten thousand dollars for bodily injury, including death, of one person in any one accident.

b. Twenty thousand dollars for bodily injury, including death, of two or more persons in any one accident.

2. The amount authorized to be paid must be within the limits provided by this section, and shall be determined as follows:

a. If the judgment creditor has effected collection of a portion of the judgment from any source, except as provided for in subdivisions b and c, the fund is authorized to pay the creditor the difference between the amount collected and the amount of the judgment, or ten thousand dollars, whichever is smaller. If the judgment creditor has collected an amount equal to the limits payable from the fund from the insurance or nonexempt assets of the judgment debtor, then the creditor is precluded from recovery from the fund.

b. If the judgment creditor has effected collection of a portion of the judgment from payment from the workmen's compensation bureau, then the amount collected from that source shall be subtracted from the judgment before the procedure outlined in subdivision a is followed.

c. If the judgment creditor was covered by an uninsured motorist insurance policy at the time of the accident, then the maximum liability limit of that policy must first be subtracted from the judgment before the procedure outlined in subdivision a is followed. If the maximum liability limit of the policy is equal to the limits payable from the fund, then no recovery from the fund is allowed.

The right of any person to recover from the unsatisfied judgment fund is not assignable and subrogation of the right is not allowed.

26.1-23-09. Order on state treasurer to pay judgment. If the court is satisfied of the truth of the matters shown by the judgment creditor as required by section 26.1-23-04, and if the applicant has taken all reasonable steps to enforce the collection of the judgment, and if there is good reason for believing that the judgment debtor has no property liable to be sold or applied in satisfaction of the judgment or of the balance owing thereon and is not insured under a policy of automobile insurance by the terms of which the insurer is liable to pay, in whole or in part, the amount of the judgment, the court shall make an order directed to the state treasurer requiring the treasurer, subject to section 26.1-23-08, to pay from the unsatisfied judgment fund the amount of the judgment or the balance owing thereon, and the state treasurer shall comply with the order.

26.1-23-10. Judgment assigned to state. Before making any payment from the unsatisfied judgment fund on any judgment in compliance with an order, the state treasurer shall require the judgment creditor to assign the judgment to the state treasurer for the use and benefit of the fund.

26.1-23-11. Order of payment from fund - Prorate distribution. If, at the time of the filing of the order, there is not sufficient moneys in the unsatisfied judgment fund to satisfy the order, the order shall be registered by the state treasurer and shall be paid when the moneys are available in the fund and subsequent orders shall be paid in the order of registration. If more than two judgments are obtained against a judgment debtor upon causes of action arising out of one accident and the aggregate amount due, after crediting any collections, exceeds twenty thousand dollars, the court in making its order shall direct that the state treasurer shall prorate the distribution from the fund in the proportion which each judgment or the balance unpaid thereon bears to the sum of twenty thousand dollars.

26.1-23-12. Amount to be repaid before privileges restored - Interest - Installment payments - Compromise of amount due. Where the operator's license or driving privileges of any person, or the registration of a motor vehicle registered in the person's name, has been suspended or revoked pursuant to the laws of this state, and the state treasurer has paid from the fund any amount toward the satisfaction of a judgment and costs recovered against the person, the suspension or revocation may not be removed, nor the operator's license or driving privileges or registration restored, nor any new license or driving privilege issued or granted to or registration be permitted to be made by the person until the person has repaid in full to the state treasurer the amount paid from the fund, together with interest thereon at the rate of six percent per annum from the date of payment, and has furnished proof of financial responsibility as required by the laws of this state. The court in which the judgment was rendered, may, upon ten days' notice to the attorney general, make an order permitting payment of the amount in installments, and in this case, the person's operator's license, driving privileges, or registration privileges, if the same have been suspended or revoked, or have expired, may be restored and shall remain in effect unless the person defaults in making any installment payment specified in the order. In the event of any default, the commissioner shall, upon notice of default, suspend the person's operator's license, driving privileges, or registration privileges until the amount of default has been paid in full and the additional sum of two hundred dollars has been paid to the fund to be applied to the judgment. The judgment debtor may petition the court in which the judgment was rendered for a compromise of the judgment. The court in its discretion, upon notice to the attorney general, may order a compromise if the court is satisfied that a compromise would be in the interests of justice and that the fund would benefit therefrom. Upon payment in full of the compromised amount, the attorney general shall issue a satisfaction of judgment to the judgment debtor. A compromise may not be ordered which is less than

five hundred dollars or twenty percent of the judgment, whichever amount is greater.

SECTION 24. Chapter 26.1-24 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-24-01. When premium payable. An insurer is entitled to payment of the premium as soon as the thing insured is exposed to the peril insured against.

26.1-24-02. Receipt for premium in policy - Effect. An acknowledgment in a policy of the receipt of premium is conclusive evidence of its payment so far as to make the policy binding, notwithstanding any stipulation in the policy that it is not binding until the premium actually is paid.

26.1-24-03. When insured entitled to return of premium. A person insured is entitled to a return of premium, including all policy fees in excess of two dollars, on any one policy, and all other sums of money paid in consideration of the policy of insurance, as follows:

1. To the whole premium, fee, or other sums if no part of the insured's interest in the thing insured is exposed to any of the perils insured against.

2. To the whole of the premium when the contract is voidable on account of the fraud or misrepresentation of the insurer or on account of facts of the existence of which the insured was ignorant without the insured's fault, or when by any default of the insured other than actual fraud, the insurer never incurred any liability under the policy.

3. When insurance other than life is made for a definite period of time and the insured surrenders the policy, to such proportion of the premium, fee, or other sum as corresponds with the unexpired time upon the amount of the policy remaining after deducting therefrom any claim for loss or damage under the policy which has accrued previously.

26.1-24-04. Premium return in cases of overinsurance. In cases of overinsurance, the insured is entitled to a return of the premium as follows:

1. In overinsurance by several insurers, to a ratable return of premium proportioned to the amount by which the aggregate sum insured in all the policies exceeds the value of the thing at risk.

2. In overinsurance effected by simultaneous policies, the insurers contribute to the premium to be returned in

proportion to the amount insured by their respective policies.

3. In overinsurance effected by successive policies, those only contribute to a return of the premium who are exonerated by prior insurance from the liability assumed by them and in proportion as the sum for which the premium was paid exceeds the amount for which, on account of prior insurance, they could be made liable.

26.1-24-05. Surrender of fire insurance policy for cancellation - Return of premium - Short-term rates. The holder of any policy of insurance against loss or damage to property by fire or other casualty, notwithstanding any provision thereof or contract to the contrary, may surrender the policy for cancellation at any time. Upon surrender, the company issuing the policy shall retain or receive such proportion, and not more, of the premium paid or agreed to be paid, including policy fees in excess of two dollars on any one policy and other sums of money paid or agreed to be paid in consideration of the policy of insurance, as corresponds with the usual short rates upon term policies as adopted and maintained by the organization which promulgates rates for fire insurance on property situated in this state for the time the policy remained in force.

26.1-24-06. Earned premium. If a peril insured against has existed and the insurer has been liable for any period, however short, the insured is not entitled to a return of premium so far as that particular risk is concerned unless the insurance was for a definite period of time, in which case the insured is entitled to a proportionate return under sections 26.1-24-03 and 26.1-24-05.

26.1-24-07. Forfeiture of policy for nonpayment of premium - Notice required. A policy of insurance may not be forfeited, suspended, or impaired, by virtue of any condition or provision thereof, for nonpayment of any note or obligation taken for the premium, or any part thereof, unless the insurer, not less than thirty days prior to the maturity of the premium, note, or obligation, mails, postage prepaid, to the insured at the insured's usual post-office address, a notice stating:

1. The date when the note or obligation will become due.

2. The amount of principal and interest that then will be due.

3. The effect of nonpayment upon the policy.

4. The right of the insured, at the insured's election, either to pay the premium in full and keep the policy in full force or to terminate the insurance by surrendering the policy and paying such part of the whole premium as it shall have earned.

5. The amount which the insured lawfully is required to pay or which, on account of previous payment, may be due the insured, in case of the insured's election to terminate the insurance on the day of the maturity of the premium, note, or obligation.

26.1-24-08. Security agreement to secure premium payment must be in separate instrument - Penalty. It is unlawful for any insurance company, or any agent or solicitor therefor within this state, to take or procure to be taken upon the property to be insured, or upon any other property, a security agreement securing the payment of the premium due or to become due, including policy fees, or any part thereof, unless the security agreement is printed or written upon a paper which is separate and distinct from the application. Any security agreement given in violation of this section is void. Any insurance company violating this section is guilty of a class A misdemeanor, and forfeits its right to do business in this state.

26.1-24-09. Sale or negotiation of premium note prohibited - Penalty. A promissory note taken in settlement of the first premium on any life, health, or accident insurance policy may not be sold or negotiated in any manner prior to the applicant's medical examination, where one is required, nor unless a binding receipt for the premium signed by an authorized agent of the insurance company has been delivered to the applicant, nor until the insurance company has received the application and medical examination. Any person violating this section is guilty of a class B misdemeanor.

SECTION 25. Chapter 26.1-25 of the North Dakota Century Code is hereby created and enacted to read as follows:

26.1-25-01. Purpose of chapter - Construction. The purpose of this chapter is to promote the public welfare by regulating insurance rates so that they are not excessive, inadequate, or unfairly discriminatory, and to authorize and regulate cooperative action among insurers in ratemaking and in other matters within the scope of this chapter. Nothing in this chapter is intended to prohibit or discourage reasonable competition, or to prohibit, or encourage except to the extent necessary to accomplish the aforementioned purpose, uniformity in insurance rates, rating systems, rating plans or practices. This chapter shall be liberally interpreted to carry into effect this section.

26.1-25-02. Scope of chapter. This chapter applies to fire, marine, inland marine, hail, windstorm, cyclone, tornado, explosion, water damage, and all other forms of insurance on property, and the loss of use and occupancy thereof, and to casualty insurance, including fidelity, surety, and guaranty bonds, and all other forms of motor vehicle insurance, as defined and set forth in subsections 1, 2, 4, 5, 6, and 7 of section 26.1-12-11 and in subsections 1, 2, 5, 6, and 7 of section 26.1-05-02, except as hereinafter excluded. Inland marine insurance is deemed to include insurance now or hereafter defined by statute, or by interpretation thereof, or if not so defined or interpreted, by ruling of the

commissioner or as established by general custom of the business, as inland marine insurance. This chapter does not apply to:

1. Reinsurance other than joint reinsurance to the extent stated in section 26.1-25-11.

2. Accident and health insurance.

3. Insurance of vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks commonly insured under marine, as distinguished from inland marine, insurance policies.

4. Insurance against loss or damage to aircraft or against liability, other than workmen's compensation and employers' liability, arising out of ownership, maintenance, or use of aircraft.

This chapter applies to every insurer, including every stock or mutual company, reciprocal or interinsurance exchange, authorized by any provision of the laws of this state to transact any of the kinds of insurance. However, this chapter does not apply to county mutual insurance companies organized under chapter 26.1-13.

If any kind of insurance, subdivision, or combination thereof, or type of coverage, subject to this chapter, is also subject to regulation by another rate regulatory act of this state, an insurer to which both acts are otherwise applicable shall file with the commissioner a designation as to which rate regulatory act is applicable to it with respect to the kind of insurance, subdivision, or combination thereof, or type of coverage.

26.1-25-03. Making of rates.

1. Rates shall be made in accordance with the following provisions:

   a. Due consideration shall be given to past and prospective loss experience within and outside this state, to any conflagration and catastrophe hazards, to a reasonable margin for underwriting profit and contingencies, to dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers, to past and prospective expenses both countrywide and those specially applicable to this state, and to all other relevant factors within and outside this state. In the case of fire insurance rates consideration shall be given to the experience of the fire insurance business during a period of not less than the most recent five-year period for which the experience is available.

b. In the case of casualty insurance the systems of expense provisions included in the rates for use by any insurer or group of insurers may differ from those of other insurers or group of insurers to reflect the requirements of the operating methods of any such insurer or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof for which subdivision or combination separate expense provisions are applicable.

c. In the case of casualty insurance risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions, or both. The standards may measure any differences among risks that can be demonstrated to have a probable effect upon losses or expense.

d. In the case of property insurance manual, minimum, class rates, rating schedules, or rating plans shall be made and adopted, except in the case of specified inland marine rates on risks specially rated.

e. Rates may not be excessive, inadequate, or unfairly discriminatory.

2. Except to the extent necessary to meet subdivision e of subsection 1, uniformity among insurers in any matters within the scope of this section is neither required nor prohibited.

3. Rates made in accordance with this section may be used subject to this chapter.

26.1-25-04. Rate filings.

1. Every insurer shall file with the commissioner, except as to inland marine risks which by general custom of the business are not written according to manual rates or rating plans, every manual, minimum class rate, rating schedule or rating plan, and every other rating rule, and every modification of any of the foregoing which it proposes to use. Every filing must state the proposed effective date thereof and must indicate the character and extent of the coverage contemplated. When a filing is not accompanied by the information upon which the insurer supports the filing, and the commissioner does not have sufficient information to determine whether the filing meets the requirements of this chapter, the commissioner shall require the insurer to furnish the information upon which it supports the filing and the waiting period

commences as of the date the information is furnished. The information furnished in support of a filing may include:

a. The experience or judgment of the insurer or rating organization making the filing.

b. Its interpretation of any statistical data upon which it relies.

c. The experience of other insurers or rating organizations.

d. Any other relevant factors.

A filing and any supporting information is open to public inspection after the filing becomes effective. Specific inland marine rates on risks specially rated, made by a rating organization, shall be filed with the commissioner.

2. An insurer may satisfy its obligation to make the filings by becoming a member of, or a subscriber to, a licensed rating organization which makes the filings, and by authorizing the commissioner to accept the filings on its behalf; provided, that this chapter does not require any insurer to become a member of or a subscriber to any rating organization.

3. The commissioner shall review filings as soon as reasonably possible after they have been made in order to determine whether they meet the requirements of this chapter.

4. Subject to the exceptions specified in subsection 5, each filing shall be on file for a waiting period of thirty days before it becomes effective. The period may be extended by the commissioner for an additional period not to exceed fifteen days if the commissioner gives written notice within the waiting period to the insurer or rating organization which made the filing that the commissioner needs the additional time for the consideration of the filing. Upon written application by the insurer or rating organization, the commissioner may authorize a filing which the commissioner has reviewed to become effective before the expiration of the waiting period or any extension thereof. A filing is deemed to meet the requirements of this chapter unless disapproved by the commissioner within the waiting period or any extension thereof.

5. Any special filing with respect to a surety or guaranty bond required by law or by court or executive order or by order or rule of a public body, not covered by a previous filing, becomes effective when filed and is deemed to meet

the requirements of this chapter until such time as the commissioner reviews the filing and so long thereafter as the filing remains in effect. Specific inland marine rates on risks specially rated by a rating organization become effective when filed and are deemed to meet the requirements of this chapter until such time as the commissioner reviews the filing and so long thereafter as the filing remains in effect.

6. Under any rules the commissioner may adopt, the commissioner may, by written order, suspend or modify the requirement of filing as to any kind of insurance, subdivision, or combination thereof, or as to classes of risks, the rates for which cannot practicably be filed before they are used. The orders and rules shall be made known to insurers and rating organizations affected thereby. The commissioner may make any examination the commissioner deems advisable to ascertain whether any rates affected by the order meet the standards set forth in subdivision e of subsection 1 of section 26.1-25-03.

7. Upon the written application of the insured, stating the insured's reasons therefor, filed with and approved by the commissioner, a rate in excess of that provided by a filing otherwise applicable may be used on any specific risk.

26.1-25-05. Disapproval of filings.

1. If within the waiting period or any extension thereof as provided in subsection 4 of section 26.1-25-04 the commissioner finds that a filing does not meet the requirements of this chapter, the commissioner shall send to the insurer or rating organization which made the filing written notice of disapproval of the filing specifying therein in what respects the commissioner finds the filing fails to meet the requirements of this chapter and stating that the filing will not become effective.

2. If within thirty days after a filing subject to subsection 5 of section 26.1-25-04 has become effective, the commissioner finds that the filing does not meet the requirements of this chapter, the commissioner shall send to the insurer or rating organization which made the filing written notice of disapproval of the filing specifying therein in what respect the commissioner finds that the filing fails to meet the requirements of this chapter and stating when, within a reasonable period thereafter, the filing will be deemed no longer effective. The disapproval may not affect any contract made or issued prior to the expiration of the period set forth in the notice.

3. If at any time subsequent to the applicable review period provided for in subsection 1 or 2 the commissioner finds that a filing does not meet the requirements of this chapter, the commissioner shall, after a hearing held upon not less than ten days' written notice, specifying the matters to be considered at the hearing, to every insurer and rating organization which made the filing, issue an order specifying in what respects the commissioner finds that the filing fails to meet the requirements of this chapter, and stating when, within a reasonable period thereafter, the filing will be deemed no longer effective. Copies of the order shall be sent to every such insurer and rating organization. The order may not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

4. Any person or organization aggrieved with respect to any filing which is in effect may make written application to the commissioner for a hearing thereon. However, the insurer or rating organization that made the filing may not proceed under this subsection. The application must specify the grounds to be relied upon by the applicant. If the commissioner finds that the application is made in good faith, that the applicant would be so aggrieved if the grounds are established, and that the grounds otherwise justify holding such a hearing, the commissioner shall, within thirty days after receipt of the application, hold a hearing upon not less than ten days' written notice to the applicant and to every insurer and rating organization which made the filing. If, after the hearing, the commissioner finds that the filing does not meet the requirements of this chapter, the commissioner shall issue an order specifying in what respects the filing fails to meet the requirements of this chapter, and stating when, within a reasonable period thereafter, the filing will be deemed no longer effective. Copies of the order shall be sent to the applicant and to every such insurer and rating organization. The order may not effect any contract or policy made or issued prior to the expiration of the period set forth in the order.

5. A manual, minimum class rate, rating schedule, rating plan, or rating rule, or any modification of any of the foregoing,. which has been filed pursuant to the requirements of section 26.1-25-04, may not be disapproved if the rates thereby produced meet the requirements of this chapter.

26.1-25-06. Rating organizations.

1. A corporation, an unincorporated association, a partnership, or an individual, whether located within or outside this state, may make application to the commissioner for license as a rating organization for such

kinds of insurance or subdivision or class of risk or a part or combination thereof as are specified in its application and shall file therewith:

a. A copy of its constitution, its articles of agreement or association or its certificate of incorporation, and of its bylaws, rules, and regulations governing the conduct of its business.

b. A list of its members and subscribers.

c. The name and address of a resident of this state upon whom notices or orders of the commissioner or process affecting the rating organization may be served.

d. A statement of its qualifications as a rating organization.

2. If the commissioner finds that the applicant is competent, trustworthy, and otherwise qualified to act as a rating organization and that its constitution, articles of agreement or association or certificate of incorporation, and its bylaws, rules, and regulations governing the conduct of its business conform to the requirements of law, the commissioner shall issue a license specifying the kinds of insurance, or subdivision or class of risk or part or combination thereof for which the applicant is authorized to act as a rating organization. Every application shall be granted or denied in whole or in part by the commissioner within sixty days of the date of its filing. Licenses issued pursuant to this section shall remain in effect for three years unless sooner suspended or revoked by the commissioner. The fee for the license is twenty-five dollars. Licenses issued pursuant to this section may be suspended or revoked by the commissioner, after hearing upon notice, in the event the rating organization ceases to meet the requirements of this subsection or subsection 1. Every rating organization shall notify the commissioner promptly of every change in:

a. Its constitution, its articles of agreement or association or its certificate of incorporation, and its bylaws, rules, and regulations governing the conduct of its business.

b. Its list of members and subscribers.

c. The name and address of the resident of this state designated by it upon whom notices or orders of the commissioner or process affecting the rating organization may be served.

3. Subject to rules and regulations which have been approved by the commissioner as reasonable, each rating

organization shall permit any insurer, not a member, to be a subscriber to its rating services for any kind of insurance, subdivision, or class of risk or a part or combination thereof for which it is authorized to act as a rating organization. Notice of proposed changes in the rules and regulations shall be given to subscribers. Each rating organization shall furnish its rating services without discrimination to its members and subscribers. The reasonableness of any rule or regulation in its application to subscribers, or the refusal of any rating organization to admit an insurer as a subscriber, shall, at the request of any subscriber, or any such insurer, be reviewed by the commissioner at a hearing held upon at least ten days' written notice to the rating organization and to the subscriber or insurer. If the commissioner finds that the rule or regulation is unreasonable in its application to subscribers, the commissioner shall order that the rule or regulation is not applicable to subscribers. If the rating organization fails to grant or reject an insurer's application for subscribership within thirty days after it was made, the insurer may request a review by the commissioner as if the application has been rejected. If the commissioner finds that the insurer has been refused admittance to the rating organization as a subscriber without justification, the commissioner shall order the rating organization to admit the insurer as a subscriber. If the commissioner finds that the action of the rating organization was justified, the commissioner shall make an order affirming its action.

4. A rating organization may not adopt any rule the effect of which would be to prohibit or regulate the payment of dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers.

5. Cooperation among rating organizations or among rating organizations and insurers in ratemaking or in other matters within the scope of this chapter is authorized; provided, the filings resulting from the cooperation are subject to all the provisions of this chapter which are applicable to filings generally. The commissioner may review the cooperative activities and practice and if, after a hearing, the commissioner finds that any such activity or practice is unfair or unreasonable or otherwise inconsistent with this chapter, the commissioner may issue a written order specifying in what respects the activity or practice is unfair or unreasonable or otherwise inconsistent with this chapter, and requiring the discontinuance of the activity or practice.

6. Any rating organization may provide for the examination of policies, daily reports, binders, renewal certificates, endorsements, or other evidences of insurance, or the

cancellation thereof, and may make reasonable rules governing their submission. The rules shall contain a provision that in the event any insurer does not within sixty days furnish satisfactory evidence to the rating organization of the correction of any error or omission previously called to its attention by the rating organization, it is the duty of the rating organization to notify the commissioner thereof. All information submitted for examination is confidential.

7. Any rating organization may subscribe for or purchase actuarial, technical, or other services, and the services shall be available to all members and subscribers without discrimination.

26.1-25-07. Deviations. Every member of or subscriber to a rating organization shall adhere to the filings made on its behalf by the organization. Provided, a casualty insurer may make written application to the commissioner for permission to file a uniform percentage decrease or increase to be applied to the premiums produced by the rating system so filed for a kind of insurance, or for a class of insurance which is found by the commissioner to be a proper rating unit for the application of such uniform percentage decrease or increase, or for a subdivision of a kind of insurance comprised of a group of manual classifications which is treated as a separate unit for ratemaking purposes, or for which separate expense provisions are included in the filings of the rating organization. Provided further, a property insurer may make written application to the commissioner for permission to file a deviation from the class rates, schedules, rating plans, or rules respecting any kind of insurance, or class of risk within a kind of insurance, or combination thereof. The application shall specify the basis for the deviation and shall be accompanied by the data upon which the applicant relies. A copy of the application and data shall be sent simultaneously to the rating organization. The commissioner shall set a time and place for a hearing at which the insurer and the rating organization may be heard and shall give them not less than ten days' written notice thereof. If the commissioner is advised by the rating organization that it does not desire a hearing, the commissioner may, upon the consent of the applicant, waive the hearing. In considering an application from a property insurer for permission to file a deviation, the commissioner shall give consideration to the available statistics and the principles for ratemaking as provided in section 26.1-25-03. The commissioner shall issue an order permitting the deviation for the insurer to be filed if the commissioner finds it to be justified and it shall thereupon become effective. The commissioner shall issue an order denying the application if the commissioner finds that the deviation is not justified, or that the resulting premiums would be excessive, inadequate, or unfairly discriminatory. Each approved deviation shall remain in force until the approval is withdrawn by the commissioner after notice to the insurer or withdrawn by the insurer with the approval of the commissioner.

26.1-25-08. Appeal by minority. Any member of or subscriber to a rating organization may appeal to the commissioner from the action or decision of the rating organization in approving or rejecting any proposed change in or addition to the filings of the rating organization and the commissioner shall, after a hearing held upon not less than ten days' written notice to the appellant and to the rating organization, issue an order approving the action or decision of the rating organization or directing it to give further consideration to the proposal, or, if the appeal is from the action or decision of the rating organization in rejecting a proposed addition to its filings, the commissioner may, if the commissioner finds that the action or decision was unreasonable, issue an order directing the rating organization to make an addition to its filings, on behalf of its members and subscribers, in a manner consistent with the commissioner's findings, within a reasonable time after the issuance of the order.

If the appeal is based upon the failure of the rating organization to make a filing on behalf of the member or subscriber which is based on a system of expense provisions which differs, in accordance with the right granted in subdivision b of subsection 1 of section 26.1-25-03, from the system of expense provisions included in a filing made by the rating organization, the commissioner shall, if an appeal is granted, order the rating organization to make the requested filing for use by the appellant. In deciding the appeal the commissioner shall apply the standards set forth in section 26.1-25-03.

26.1-25-09. Information to be furnished insureds - Hearings and appeals of insureds. Every rating organization and every insurer which makes its own rates shall, within a reasonable time after receiving written request therefor and upon payment of such reasonable charge as it may make, furnish to any insured affected by a rate made by it, or to the authorized representative of such insured, all pertinent information as to the rate. Every rating organization and every insurer which makes its own rates shall provide within this state reasonable means whereby any person aggrieved by the application of its rating system may be heard, in person or by an authorized representative, on the person's written request to review the manner in which the rating system has been applied in connection with the insurance afforded the person. If the rating organization or insurer fails to grant or reject the request within thirty days after it is made, the applicant may proceed in the same manner as if the application had been rejected. Any party affected by the action of the rating organization or the insurer on the request may, within thirty days after written notice of the action, appeal to the commissioner, who, after a hearing held upon not less than ten days' written notice to the appellant and to the rating organization or insurer, may affirm or reverse the action.

26.1-25-10. Advisory organizations.

1. Every group, association, or other organization of insurers, whether located within or outside this state,

which assists insurers which make their own filings or rating organizations in ratemaking, by the collection and furnishing of loss or expense statistics, or by the submission of recommendations, but which does not make filings under this chapter, shall be known as an advisory organization.

2. Every advisory organization shall file with the commissioner:

   a. A copy of its constitution, its articles of agreement or association or its certificates of incorporation, and its bylaws, rules, and regulations governing its activities.

   b. A list of its members.

   c. The name and address of a resident of this state upon which notices or orders of the commissioner or process issued at the commissioner's direction may be served.

   d. An agreement that the commissioner may examine the advisory organization in accordance with section 26.1-25-12.

3. If, after a hearing, the commissioner finds that the furnishing of the information or assistance involves any act or practice which is unfair or unreasonable or otherwise inconsistent with this chapter, the commissioner may issue a written order specifying in what respects the act or practice is unfair or unreasonable or otherwise inconsistent with this chapter, and requiring the discontinuance of the act or practice.

4. An insurer which makes its own filings and any rating organization may not support its filings by statistics or adopt ratemaking recommendations, furnished to it by an advisory organization which has not complied with this section or with an order of the commissioner involving such statistics or recommendations issued under subsection 3. If the commissioner finds the insurer or rating organization to be in violation of this subsection the commissioner may issue an order requiring the discontinuance of the violation.

26.1-25-11. Joint underwriting or joint reinsurance.

1. Every group, association, or other organization of insurers which engages in joint underwriting or joint reinsurance is subject to regulation with respect thereto as herein provided, subject, however, with respect to joint underwriting, to all other provisions of this chapter and, with respect to joint reinsurance, to

sections 26.1-25-12, 26.1-25-16, 26.1-25-17, and 26.1-25-18.

2. If, after a hearing, the commissioner finds that any activity or practice of any such group, association, or other organization is unfair or unreasonable or otherwise inconsistent with this chapter, the commissioner may issue a written order specifying in what respects the activity or practice is unfair or unreasonable or otherwise inconsistent with this chapter, and requiring the discontinuance of the activity or practice.

26.1-25-12. Examinations. The commissioner shall, at least once in five years, make or cause to be made an examination of each rating organization licensed in this state. The commissioner may, as often as the commissioner deems expedient, make or cause to be made an examination of each advisory organization referred to in section 26.1-25-10 and of each group, association, or other organization referred to in section 26.1-25-11. The reasonable costs of any examination shall be paid by the rating organization, advisory organization, or group, association, or other organization examined upon presentation to it of a detailed account of the costs. The officer, manager, agents, and employees of the rating organization, advisory organization, or group, association, or other organization may be examined at any time under oath and shall exhibit all books, records, accounts, documents, or agreements governing its method of operation.

The commissioner shall furnish two copies of the examination report to the organization, group, or association examined and shall notify the organization, group, or association that it may, within twenty days thereafter, request a hearing on the report or on any facts or recommendations therein. Before filing any report for public inspection, the commissioner shall grant a hearing to the organization, group, or association examined. The report of any examination, when filed for public inspection, is admissible in evidence in any action or proceeding brought by the commissioner against the organization, group, or association examined, or its officers or agents, and is prima facie evidence of the facts stated therein. The commissioner may withhold the report of any examination from public inspection for the time as the commissioner deems proper.

In lieu of any such examination the commissioner may accept the report of an examination made by the insurance supervisory official of another state, pursuant to the laws of that state.

26.1-25-13. Rate administration.

1. The commissioner shall adopt reasonable rules and statistical plans, reasonably adopted to each of the rating systems on file with the commissioner, which may be modified from time to time and which shall be used thereafter by each insurer in the recording and reporting

of its loss and countrywide expense experience, in order that the experience of all insurers may be made available at least annually in such form and detail as may be necessary to aid the commissioner in determining whether rating systems comply with the standards set forth in section 26.1-25-03. The rules and plans may also provide for the recording and reporting of expense experience items which are specially applicable to this state and are not susceptible of determination by a prorating of countrywide expense experience. In adopting the rules and plans, the commissioner shall give due consideration to the rating systems on file with the commissioner and, in order that the rules and plans may be as uniform as is practicable among the several states, to the rules and to the form of the plans used for the rating systems in other states. No insurer may be required to record or report its loss experience on a classification basis that is inconsistent with the rating system filed by it. The commissioner may designate one or more rating organizations or other agencies to assist the commissioner in gathering such experience and making compilations thereof, and the compilations shall be made available, subject to reasonable rules adopted by the commissioner, to insurers and rating organizations.

2. Reasonable rules and plans may be adopted by the commissioner for the interchange of data necessary for the application of rating plans.

3. In order to further uniform administration of rate regulatory laws, the commissioner and every insurer and rating organization may exchange information and experience data with insurance supervisory officials, insurers, and rating organizations in other states and may consult with them with respect to ratemaking and the application of rating systems.

4. The commissioner may adopt reasonable rules necessary to effect the purposes of this chapter.

26.1-25-14. False or misleading information. No person or organization may willfully withhold information from, or knowingly give false or misleading information to, the commissioner, any statistical agency designated by the commissioner, any rating organization, or any insurer, which will affect the rates or premiums chargeable under this chapter. A violation of this section subjects the offender to the penalties provided in section 26.1-25-18.

26.1-25-15. Assigned risks. Agreements may be made among insurers with respect to the equitable apportionment among them of insurance which may be afforded applicants who are in good faith entitled to but who are unable to procure such insurance through ordinary methods and the insurers may agree among themselves on the

use of reasonable rate modifications for such insurance. These agreements and rate modifications are subject to the approval of the commissioner.

26.1-25-16. Rebates prohibited. No broker or agent may knowingly charge, demand, or receive a premium for any policy of insurance except in accordance with this chapter. No insurer or employee thereof, and no broker or agent may pay, allow, or give, or offer to pay, allow, or give, directly or indirectly, as an inducement to insurance, or after insurance has been effected, any rebate, discount, abatement, credit, or reduction of the premium named in a policy of insurance, or any special favor or advantage in the dividends or other benefits to accrue thereon, or any valuable consideration or inducement whatever, not specified in the policy of insurance, except to the extent provided for in applicable filing. No insured named in a policy of insurance, nor any employee of such insured may knowingly receive or accept, directly or indirectly, any such rebate, discount, abatement, credit, or reduction of premium, or any such special favor or advantage or valuable consideration or inducement. This section does not prohibit the payment of commissions or other compensation to licensed agents or brokers, nor any insurer from allowing or returning to its participating policyholders, members, or subscribers, dividends, savings, or unabsorbed premium deposits. As used in this section the word "insurance" includes suretyship and the word "policy" includes bond.

26.1-25-17. Hearing procedure and judicial review. Any insurer or rating organization aggrieved by any order or decision of the commissioner made without a hearing may, within thirty days after notice of the order to the insurer or organization, make written request to the commissioner for a hearing thereon. The commissioner shall hear the party within twenty days after receipt of the request and shall give not less than ten days' written notice of the time and place of the hearing. Within fifteen days after the hearing the commissioner shall affirm, reverse, or modify the previous action, specifying the reasons therefor. Pending the hearing and decision thereon the commissioner may suspend or postpone the effective date of the previous action. This chapter does not require the observance at any hearing of formal rules of pleading or evidence.

26.1-25-18. Penalties. Any person who violates this chapter shall be guilty of a class B misdemeanor.

The commissioner may suspend the license of any rating organization or insurer which fails to comply with the order of the commissioner with the time limited by the order or any extension thereof which the commissioner may grant. However, no right to suspend any license exists until after the time for appeal from the order has expired, or if an appeal has been taken, until the order has been affirmed, and no right of suspension exists if prompt compliance with the order is made following the expiration of the time for appeal or the entry of a final order or judgment of affirmance upon appeal. The commissioner may determine when a suspension becomes effective and it shall remain in effect for the

period fixed by the commissioner, unless the commissioner modifies or rescinds the suspension, or until the order upon which the suspension is based is modified, rescinded, or reversed.

A license may not be suspended or revoked except upon a written order of the commissioner, stating the findings, made after a hearing held upon not less than ten days' written notice to the person or organization specifying the alleged violation.

* **SECTION 26. REPEAL.** Sections 6-05-19, 6-05-20, 6-05-21, 6-05-23, 6-05-24, 6-05-30, 6-05-31, 6-05-32, 6-05-33, chapters 26-01 and 26-04, section 26-05-03, chapters 26-07, 26-08, 26-09, 26-09.1, sections 26-10-03, 26-10-04, 26-10-05, 26-10-09, 26-10-10, 26-10-11, 26-10-13.1, 26-10-15, chapters 26-11, 26-12, 26-14, 26-15, 26-16, sections 26-17.1-50, 26-17.1-51, 26-17.1-52, 26-17.1-53, 26-18-02, chapters 26-20, 26-21, 26-21.1, 26-23, 26-24, 26-25, 26-26, 26-27, 26-27.1, 26-27.2, 26-28, 26-29, 26-30, 26-32, 26-37, 26-38, 26-40, and 39-17 of the North Dakota Century Code, and sections 6-05-22, 26-10-02, 26-10-14, 26-10-16, chapter 26-16.1, sections 26-18-01 and 26-18-12, chapters 26-21.2 and 26-27.3 of the 1981 Supplement to the North Dakota Century Code are hereby repealed.

SECTION 27. TEMPORARY TRANSITION. Any reference to "this title" in title 26 includes title 26.1 and any reference to "this title" in title 26.1 includes title 26. Any reference to title 26 in the North Dakota Century Code includes title 26.1. This section is effective until title 26 has been completely repealed and replaced by title 26.1.

SECTION 28. TRANSITION - APPLICATION TO EXISTING INSURERS. Any association, company, corporation, exchange, organization, or society authorized, established, incorporated, or organized under provisions of title 26 as it existed on June 30, 1983, is deemed to have been authorized, established, incorporated, or organized under the appropriate provisions of title 26.1.

SECTION 29. EMERGENCY. Section 26.1-02-20 is hereby declared to be an emergency measure and is in effect from and after its passage and approval.

Approved March 16, 1983

* NOTE: Section 26-21.2-10 was amended by section 52 of House Bill No. 1058, chapter 82; section 26-21.1-14 was also repealed by section 154 of House Bill No. 1058, chapter 82.

CHAPTER 333

SENATE BILL NO. 2493
(Nething, Redlin)
(Approved by the Committee on Delayed Bills)

INSURANCE PREMIUM TAX

AN ACT to amend and reenact sections 26-01-11, 26-16-10, 26-27-13, and 26-40-14 of the North Dakota Century Code, or in the alternative to amend and reenact sections 26.1-03-17, 26.1-09-10, 26.1-14-13, and 26.1-17-10 of the North Dakota Century Code as created by House Bill No. 1054 and amended by House Bill No. 1068, as approved by the forty-eighth legislative assembly, relating to insurance premium taxes; to provide for retroactive application; to provide a penalty; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. AMENDMENT. If House Bill No. 1054 and House Bill No. 1068 do not become effective, section 26-01-11 of the 1981 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-01-11. Commissioner of insurance to collect premium tax - Insurance companies generally - ~~Domestic fire insurance companies~~-- Computation - Credits - Penalty.

1. Before issuing the annual certificate required by law, the commissioner of insurance shall collect ~~the following annual taxes from insurance companies doing business within the state:~~

~~1.~~ ~~From~~ from every stock and mutual insurance company, nonprofit health service corporation, health maintenance organization, and prepaid legal service organization doing business in this state ~~except stock and mutual companies organized under the laws of this state~~, a tax ~~equal in amount to two and one-half percent of~~ on the gross amount of premiums, assessments, membership fees, ~~and~~ subscriber fees, policy fees, and finance and service charges received in this state during the preceding ~~year, such~~ calendar quarter, at the rate of two percent with respect to life insurance, one-half of one percent with respect to

accident and sickness insurance, and one percent with respect to all other lines of insurance. The tax ~~to be~~ is payable ~~at the time when the annual statement of business required by law is filed; provided, however, that~~ on or before the sixtieth day after the last day of the calendar quarter and shall be deposited in the general fund in the state treasury. However, this tax shall not apply to considerations for annuities.

2. ~~From every domestic fire insurance company, whether mutual, stock, or otherwise, a tax upon its fire insurance premiums or assessments, or both, equal to one-half of one percent of the gross premiums and assessments, less return premiums on all direct business received by it, or by its agent for it, in cash or otherwise in this state. Such tax shall be collected for the purpose of assisting in the maintenance of the fire marshal's department and shall be payable on or before March first in each year.~~ An insurance company, nonprofit health service corporation, health maintenance organization, or prepaid legal service organization subject to the tax imposed by subsection 1 is entitled to a credit against the tax due for an amount equal to the examination fees paid to the commissioner under section 26-01-04 and sections 26-01-06 through 26-01-10 and a credit against the tax due for 1982, 1983, 1984, and 1985 for an amount equal to the ad valorem taxes, whether direct or in the form of rent, on that proportion of premises occupied as the principal office in this state for over one-half of the year for which the tax is paid. The credits under this subsection shall be prorated on a quarterly basis and may not exceed the total tax liability under subsection 1.

3. After March 1, 1984, any person failing to pay the tax imposed by subsection 1, within the time required, is subject to a penalty of five percent of the amount of tax due or one hundred dollars, whichever is greater, plus six percent of the tax for each day of delay, excepting the first day after the tax became due.

SECTION 2. AMENDMENT. If House Bill No. 1054 does not become effective but House Bill No. 1068 does become effective, section 26-01-11 of the 1981 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-01-11. Commissioner of insurance to collect premium tax - Insurance companies generally - ~~Domestic fire insurance companies~~-- Computation - Credits - Penalty.

1. Before issuing the annual certificate required by law, the commissioner of insurance shall collect ~~the following annual taxes from insurance companies doing business within the state:~~

~~1.~~ ~~From~~ from every stock and mutual insurance company, nonprofit health service corporation, health maintenance organization, and prepaid legal service organization doing business in this state ~~except stock and mutual companies organized under the laws of this state~~, a tax ~~equal in amount to two and one-half percent of~~ on the gross amount of premiums, assessments, membership fees, ~~and~~ subscriber fees, policy fees, and finance and service charges received in this state during the preceding ~~year, such~~ calendar quarter, at the rate of two percent with respect to life insurance, one-half of one percent with respect to accident and sickness insurance, and one percent with respect to all other lines of insurance. The tax ~~to be~~ is payable ~~at the time when the annual statement of business required by law is filed, provided, however, that~~ on or before the sixtieth day after the last day of the calendar quarter and shall be deposited in the general fund in the state treasury. However, this tax shall not apply to considerations for annuities.

2. ~~From every domestic fire insurance company, whether mutual, stock, or otherwise, a tax upon its fire insurance premiums or assessments, or both, equal to one-half of one percent of the gross premiums and assessments, less return premiums on all direct business received by it, or by its agent for it, in cash or otherwise in this state. Such tax shall be collected for the purpose of assisting in the maintenance of the fire marshal's department and shall be payable on or before March first in each year. The~~ An insurance company, nonprofit health service corporation, health maintenance organization, or prepaid legal service organization subject to the tax imposed by subsection 1 is entitled to a credit against the tax due for the amount of any assessment paid ~~by any~~ as a member of a comprehensive health association under subsection 4 of section 26-16.1-08 ~~is a credit against the premium and income tax~~ for which the member may be liable for the year in which the assessment was paid, a credit for an amount equal to the examination fees paid to the commissioner under section 26-01-04 and sections 26-01-06 through 26-01-10, and a credit against the tax due for 1982, 1983, 1984, and 1985 for an amount equal to the ad valorem taxes, whether direct or in the form of rent, on that proportion of premises occupied as the principal office in this state for over one-half of the year for which the tax is paid. The credits under this subsection shall be prorated on a quarterly basis and may not exceed the total tax liability under subsection 1.

3. After March 1, 1984, any person failing to pay the tax imposed by subsection 1, within the time required, is subject to a penalty of five percent of the amount of tax due or one hundred dollars, whichever is greater, plus six

percent of the tax for each day of delay, excepting the first day after the tax became due.

SECTION 3. AMENDMENT. If House Bill No. 1054 does not become effective, section 26-16-10 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-16-10. Attorney's license fee and gross premium tax in lieu of other taxes. The attorney, in lieu of all other state, county, or municipal fees and taxes of any and every character in this state, shall pay annually to the state, on account of the transaction of the reciprocal or interinsurance exchange business in this state, a license fee of fifteen dollars and a tax ~~of two and one-half percent of~~ as provided in section 26-01-11 on the gross premiums or deposits collected from subscribers in this state after deducting therefrom all sums returned to such subscribers or credited to their accounts other than for losses.

SECTION 4. AMENDMENT. If House Bill No. 1054 does not become effective, section 26-27-13 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-27-13. Funds of medical care corporations tax exempt - Insurance premium tax - Law governing charitable organizations applicable. Every corporation subject to the provisions of this chapter is hereby declared to be a charitable and benevolent organization and its funds shall be exempt from taxation by the state or any political subdivision thereof, except for the tax imposed by section 26-01-11. Except as otherwise provided in this chapter, the laws of this state relating to and affecting nonprofit charitable and benevolent corporations shall be applicable to all corporations created under the provisions of this chapter, with the exception that the real property of such corporations shall be subject to taxation.

SECTION 5. AMENDMENT. If House Bill No. 1054 does not become effective, section 26-40-14 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-40-14. Exemption from taxation. The property, income, premiums, and activities of the company are exempt from all taxes and assessments and from any fees specified for licenses and certifications of the insurance laws ~~with the exception of~~ except for the tax imposed by section 26-01-11 and any assessment made by the insurance guaranty association in the event that an affirmative election is held in accordance with section 26-40-12.

SECTION 6. AMENDMENT. If House Bill No. 1068 does not become effective, section 26.1-03-17 of the North Dakota Century Code as created by House Bill No. 1054, as approved by the forty-eighth legislative assembly, is hereby amended and reenacted to read as follows:

26.1-03-17. Commissioner to collect premium tax - Insurance companies generally - ~~Domestic fire companies~~ -- Computation - Credits - Penalty.

1. Before issuing the annual certificate required by law, the commissioner shall collect ~~the following annual taxes from insurance companies doing business within the state:~~

~~1.~~ ~~From~~ from every stock and mutual insurance company, nonprofit health service corporation, health maintenance organization, and prepaid legal service organization, except a fraternal benefit society, doing business in this state ~~except stock and mutual companies organized under the laws of this state~~, a tax ~~equal in amount to two and one-half percent of~~ on the gross amount of premiums, assessments, membership fees, ~~and~~ subscriber fees, policy fees, and finance and service charges received in this state during the preceding ~~year~~ calendar quarter, at the rate of two percent with respect to life insurance, one-half of one percent with respect to accident and sickness insurance, and one percent with respect to all other lines of insurance. This tax ~~shall~~ does not apply to considerations for annuities. The tax is payable ~~at the time when the annual statement of business required by law is filed~~ on or before the sixtieth day after the last day of the calendar quarter and shall be deposited in the general fund in the state treasury.

2. ~~From every domestic fire insurance company, whether mutual, stock, or otherwise, a tax upon its fire insurance premiums or assessments, or both, equal to one-half of one percent of the gross premiums and assessments, less return premiums on all direct business received by it, or by its agent for it, in cash or otherwise in this state. The tax is collected for the purpose of assisting in the maintenance of the fire marshal's department and is payable on or before March first of each year.~~ An insurance company, nonprofit health service corporation, health maintenance organization, or prepaid legal service organization subject to the tax imposed by subsection 1 is entitled to a credit against the tax for an amount equal to the examination fees paid to the commissioner under sections 26.1-01-07, 26.1-02-02, and 26.1-03-19 through 26.1-03-22 and a credit against the tax due for 1982, 1983, 1984, and 1985 for an amount equal to the ad valorem taxes, whether direct or in the form of rent, on that proportion of premises occupied as the principal office in this state for over one-half of the year for which the tax is paid. The credits under this subsection shall be prorated on a quarterly basis and may not exceed the total tax liability under subsection 1.

3. After March 1, 1984, any person failing to pay the tax imposed by subsection 1, within the time required, is subject to a penalty of five percent of the amount of tax due or one hundred dollars, whichever is greater, plus six percent of such tax for each day of delay, excepting the first day after the tax became due.

SECTION 7. AMENDMENT. Section 26.1-03-17 of the North Dakota Century Code as created by House Bill No. 1054 and as amended by House Bill No. 1068, as approved by the forty-eighth legislative assembly, is hereby amended and reenacted to read as follows:

26.1-03-17. Commissioner to collect premium tax - Insurance companies generally - ~~Domestic fire companies--~~ Computation - Credits - Penalty.

1. Before issuing the annual certificate required by law, the commissioner shall collect ~~the following annual taxes from insurance companies doing business within the state:~~

~~1.~~ ~~From~~ from every stock and mutual insurance company, nonprofit health service corporation, health maintenance organization, and prepaid legal service organization, except a fraternal benefit society, doing business in this state ~~except stock and mutual companies organized under the laws of this state~~, a tax ~~equal in amount to two and one-half percent of~~ on the gross amount of premiums, assessments, membership fees, ~~and~~ subscriber fees, policy fees, and finance and service charges received in this state during the preceding ~~year~~ calendar quarter, at the rate of two percent with respect to life insurance, one-half of one percent with respect to accident and sickness insurance, and one percent with respect to all other lines of insurance. This tax ~~shall~~ does not apply to considerations for annuities. The tax is payable ~~at the time when the annual statement of business required by law is filed~~ on or before the sixtieth day after the last day of the calendar quarter and shall be deposited in the general fund in the state treasury.

2. ~~From every domestic fire insurance company, whether mutual, stock, or otherwise, a tax upon its fire insurance premiums or assessments, or both, equal to one-half of one percent of the gross premiums and assessments, less return premiums on all direct business received by it, or by its agent for it, in cash or otherwise in this state. The tax is collected for the purpose of assisting in the maintenance of the fire marshal's department and is payable on or before March first of each year. The~~ An insurance company, nonprofit health service corporation, health maintenance organization, or prepaid legal service organization subject to the tax imposed by subsection 1 is entitled to a credit against the tax due for the amount of any assessment paid ~~by any~~ as a member of a comprehensive health association under subsection 4 of section 26.1-08-09 ~~is a credit against the premium tax~~ for which the member may be liable for the year in which the assessment was paid, a credit against the tax due for an amount equal to the examination fees paid to the commissioner under sections 26.1-01-07, 26.1-02-02, and 26.1-03-19 through 26.1-03-22, and a credit against the tax due for 1982, 1983, 1984, and 1985 for an amount equal

to the ad valorem taxes, whether direct or in the form of rent, on that proportion of premises occupied as the principal office in this state for over one-half of the year for which the tax is paid. The credits under this subsection shall be prorated on a quarterly basis and may not exceed the total tax liability under subsection 1.

3. After March 1, 1984, any person failing to pay the tax imposed by subsection 1, within the time required, is subject to a penalty of five percent of the amount of tax due or one hundred dollars, whichever is greater, plus six percent of such tax for each day of delay, excepting the first day after the tax became due.

SECTION 8. AMENDMENT. Section 26.1-09-10 of the North Dakota Century Code as created by House Bill No. 1054, as approved by the forty-eighth legislative assembly is hereby amended and reenacted to read as follows:

26.1-09-10. Attorney's license fee and gross premium tax in lieu of other taxes. The attorney, in lieu of all other state, county, or municipal fees and taxes of any and every character in this state, shall pay annually to the state, on account of the transaction of the reciprocal or interinsurance exchange business in this state, a license fee of fifteen dollars and a tax ~~of two and one-half percent of~~ as provided by section 26.1-03-17 on the gross premiums or deposits collected from subscribers in this state after deducting therefrom all sums returned to the subscribers or credited to their accounts other than for losses.

SECTION 9. AMENDMENT. Section 26.1-14-13 of the North Dakota Century Code as created by House Bill No. 1054, as approved by the forty-eighth legislative assembly, is hereby amended and reenacted to read as follows:

26.1-14-13. Exemption from taxation. The property, income, premiums, and activities of the company are exempt from all taxes and assessments and from any fees specified for licenses and certifications of the insurance laws ~~with the exception of~~ except for the tax imposed by section 26.1-03-17 and any assessment made by the insurance guaranty association in the event that an affirmative election is held in accordance with section 26.1-14-15.

SECTION 10. AMENDMENT. Section 26.1-17-10 of the North Dakota Century Code as created by House Bill No. 1054, as approved by the forty-eighth legislative assembly, is hereby amended and reenacted to read as follows:

26.1-17-10. Nonprofit corporation tax exempt - Insurance premium tax - Law governing charitable organizations applicable. Every nonprofit health service corporation is a charitable and benevolent organization and is exempt from taxation by the state or any political subdivision thereof, except that the tax imposed by section 26.1-03-17 is applicable to a corporation subject to this chapter and the real

property of a nonprofit health service corporation is subject to ad valorem taxes and special assessments for special improvements. Except as otherwise provided in this chapter, the laws of this state relating to and affecting nonprofit charitable and benevolent corporations are applicable to all nonprofit health service corporations writing health service contracts.

SECTION 11. RETROACTIVE APPLICATION. This Act is retroactive and applies to taxable years beginning after December 31, 1981, except for nonprofit health service corporations and health maintenance organizations. With respect to nonprofit health service corporations and health maintenance organizations, this Act applies to taxable years beginning after December 31, 1982. A taxpayer who paid the tax imposed by section 26-01-11 on the 1982 premium year or who paid state income tax for the 1982 tax year before the passage and approval of this Act is entitled to a credit against the tax imposed by this Act in an amount equal to the tax paid. The credit shall be applied against the tax imposed for 1982 and any remaining credit shall be applied against the tax imposed for 1983. The credit may not exceed the tax imposed by this Act for 1982 and 1983. If a taxpayer was not subject to the tax imposed by section 26-01-11 before January 1, 1982, the tax imposed by this Act on that taxpayer is payable within sixty days after the effective date of this Act.

SECTION 12. EMERGENCY. This Act is hereby declared to be an emergency measure and is in effect from and after its passage and approval.

Approved April 28, 1983

CHAPTER 334

SENATE BILL NO. 2270
(Lips)

UNFAIR PRACTICE REGARDING HMO OPTION

AN ACT to amend and reenact subsection 11 of section 26-30-04 of the North Dakota Century Code, or in the alternative to amend and reenact subsection 11 of section 26.1-04-03 of the North Dakota Century Code, relating to the definition of unfair methods of competition and unfair or deceptive acts or practices with respect to insurance; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. AMENDMENT. If House Bill No. 1054 does not become effective, subsection 11 of section 26-30-04 of the 1981 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

11. Refusing to insure risks. Refusing to insure risks solely because of race, color, creed, sex, or national origin, or refusing to continue to insure risks solely because an employer chooses to offer a health maintenance organization option to employees in its health benefit plan.

SECTION 2. AMENDMENT. Subsection 11 of section 26.1-04-03 of the North Dakota Century Code as created by House Bill No. 1054, as approved by the forty-eighth legislative assembly, is hereby amended and reenacted to read as follows:

11. Refusing to insure risks. Refusing to insure risks solely because of race, color, creed, sex, or national origin, or refusing to continue to insure risks solely because an employer chooses to offer a health maintenance organization option to employees in its health benefit plan.

SECTION 3. EMERGENCY. This Act is hereby declared to be an emergency measure and is in effect from and after its passage and approval.

Approved March 29, 1983

CHAPTER 335

HOUSE BILL NO. 1615
(G. Martin, Kuchera, Black, Gates)

VISUAL ACUITY AS FACTOR IN LIFE OR HEALTH POLICIES

AN ACT to create and enact a new section to chapter 26-30 of the North Dakota Century Code, or in the alternative to create and enact a new section to chapter 26.1-04 of the North Dakota Century Code as created by House Bill No. 1054, as approved by the forty-eighth legislative assembly, relating to the use of visual acuity as a factor in issuing, rejecting, and rating policies or contracts of life or health protection.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. If House Bill No. 1054 does not become effective, a new section to chapter 26-30 of the North Dakota Century Code is hereby created and enacted to read as follows:

Visual acuity prohibited as factor in life or accident and sickness contracts. No person, benevolent society, nonprofit medical service corporation, or health maintenance organization may issue any policy, certificate, or contract on life, accident and sickness, medical service, or health care protection for which visual acuity is used as a criteria for accepting or rejecting risks or for the setting of rates charged for that coverage except where the refusal, limitation, or rate differential is based on sound actuarial principles.

SECTION 2. A new section to chapter 26.1-04 of the North Dakota Century Code as created by House Bill No. 1054, as approved by the forty-eighth legislative assembly, is hereby created and enacted to read as follows:

Visual acuity prohibited as factor in life or accident and sickness contracts. No insurance company, benevolent society, nonprofit health service corporation, or health maintenance organization may issue any policy, certificate, or contract on life, accident and sickness, health services, or health care protection for which visual acuity is used as a criteria for accepting or rejecting risks or for setting of rates charged for that coverage except where the refusal, limitation, or rate differential is based on sound actuarial principles.

Approved March 10, 1983

CHAPTER 336

SENATE BILL NO. 2280
(Lips)

INSURANCE COMPANY PROHIBITED INVESTMENTS

AN ACT to amend and reenact section 26-08-10 of the North Dakota Century Code, or in the alternative to amend and reenact section 26.1-05-18 of the North Dakota Century Code as created by House Bill No. 1054, as approved by the forty-eighth legislative assembly, relating to directors authorizing the investment of funds and prohibited investment practices by domestic insurance companies.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. AMENDMENT. If House Bill No. 1054 does not become effective, section 26-08-10 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-08-10. Investment of funds must be authorized by directors - Investment practices which are prohibited. No investment or loan, except a policy loan, shall be made by any domestic insurance company unless the same first shall have been authorized by the board of directors of the company or by an investment committee appointed by the board of directors of the company charged with the duty of supervising the making of loans or investments by the company. No domestic insurance company shall:

1. Subscribe to or participate in any underwriting of the purchase or sale of securities or property.

2. Enter into any transaction for the purchase or sale of any securities or property on account of said company jointly with any other person, firm, or corporation, except for authorized real estate joint ventures and partnerships.

3. Enter into any agreement to withhold any of its property from sale, but the disposition of its property at all times shall be within the control of its board of directors, except for authorized real estate joint ventures and partnerships.

4. Invest any of its funds in, or loan the same upon, the shares of stock of any corporation except as otherwise provided herein.

5. Invest any of its funds in, or loan the same upon, any bonds or obligations, except government, state, or municipal securities, which are not secured by adequate collateral security to the full extent of the investment, except as otherwise provided herein.

6. Invest its capital, surplus funds, or other assets in, or loan the same upon, any property owned by any officer or director of the company, or by any of the immediate members of the family of any such officer or director, nor in any manner which will permit any such officer or director to gain through the investment of funds of the company.

SECTION 2. AMENDMENT. Section 26.1-05-18 of the North Dakota Century Code as created by House Bill No. 1054, as approved by the forty-eighth legislative assembly, is amended and reenacted to read as follows:

26.1-05-18. Investment of funds must be authorized by directors - Prohibited investment practices. An investment or loan, except a policy loan, may not be made by any domestic insurance company unless the investment or loan first has been authorized by the board of directors of the company or by an investment committee appointed by the board of directors of the company charged with the duty of supervising the making of loans or investments by the company. A domestic insurance company may not:

1. Subscribe to or participate in any underwriting of the purchase or sale of securities or property.

2. Enter into any transaction for the purchase or sale of any securities or property on account of the company jointly with any other person, firm, or corporation, except for authorized real estate joint ventures and partnerships.

3. Enter into any agreement to withhold any of its property from sale, but the disposition of its property at all times is within the control of its board of directors, except for authorized real estate joint ventures and partnerships.

4. Invest any of its funds in, or loan the funds upon, the shares of stock of any corporation except as otherwise provided in this chapter.

5. Invest any of its funds in, or loan the funds upon, any bonds or obligations, except government, state or municipal securities, which are not secured by adequate

collateral security to the full extent of the investment, except as otherwise provided in this chapter.

6. Invest its capital, surplus funds, or other assets in, or loan the same upon, any property owned by an officer or director of the company, or by any of the immediate members of the family of any such officer or director, nor in any manner which will permit any such officer or director to gain through the investment of funds of the company.

Approved March 17, 1983

CHAPTER 337

SENATE BILL NO. 2283
(Lips)

INSURANCE COMPANY DATA PROCESSING SYSTEM INVESTMENT

AN ACT to amend and reenact section 26-08-11.1 of the North Dakota Century Code, or in the alternative to amend and reenact subsection 6 of section 26.1-05-19 of the North Dakota Century Code as created by House Bill No. 1054, relating to investments in a data processing system by domestic insurance companies.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. AMENDMENT. If House Bill No. 1054 does not become effective, section 26-08-11.1 of the 1981 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-08-11.1. Investment in data processing system. Any domestic insurance company heretofore or hereafter organized under any law of this state may invest by loans or otherwise, with the direction or approval of a majority of its board of directors or authorized committee thereof, any of its funds, or any part thereof in the purchase of electric or mechanical machines, including software, constituting a data processing system, and thereafter may hold the system as an admitted asset for use in connection with the business of the company if, (1) its aggregate cost shall not exceed five percent of the admitted assets of the company; (2) the cost of the ~~component machines~~ components constituting the system shall be fully amortized over a period of not to exceed ~~ten~~ seven years. If a data processing system consists of separate ~~component machines~~ components which are acquired at different times, then the cost of each component shall be amortized over a period not to exceed ~~ten~~ seven years commencing with the date of acquisition of each component.

* SECTION 2. AMENDMENT. Subsection 26 of section 26.1-05-19 of the North Dakota Century Code as created by House Bill No. 1054, as approved by the forty-eighth legislative assembly, is amended and reenacted to read as follows:

* NOTE: Section 26.1-05-19 was amended by section 2 of Senate Bill No. 2279, chapter 338.

26. Investments by loans or otherwise, in the purchase of electric or mechanical machines, including software, constituting a data processing system. The company may hold the system as an admitted asset for use in connection with the business of the company if, (a) its aggregate cost does not exceed five percent of the admitted assets of the company; (b) the cost of the ~~component machines~~ components constituting the system ~~is~~ are fully amortized over a period not to exceed ~~ten~~ seven years. If a data processing system consists of separate ~~component machines~~ components acquired at different times, then the cost of each component must be amortized over a period not to exceed ~~ten~~ seven years commencing with the date of acquisition of each component.

Approved March 10, 1983

CHAPTER 338

SENATE BILL NO. 2279
(Lips)

INSURANCE COMPANY INVESTMENTS

AN ACT to amend and reenact section 26-08-11 of the North Dakota Century Code, or in the alternative to amend and reenact section 26.1-05-19 of the North Dakota Century Code as amended by House Bill No. 1054, as approved by the forty-eighth legislative assembly, relating to authorized investments for domestic insurance companies.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. AMENDMENT. If House Bill No. 1054 does not become effective, section 26-08-11 of the 1981 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-08-11. Authorized investment of funds of insurance companies. A domestic insurance company may invest any of its funds and accumulations in:

1. Securities or obligations which are made eligible specifically to such investment by law.

2. a. Bonds or other evidence of indebtedness issued, assumed, or guaranteed by the United States of America, the District of Columbia, or by any state, insular or territorial possession of the United States or by any county, city, township, duly organized school district, municipality, or other civil division therein, including those payable from special revenues or earnings specifically pledged for the payment thereof, and those payable from special assessments, <u>including rights to purchase or sell these securities or obligations if these rights are traded upon a contract market designated and regulated by a federal agency and purchased for legitimate hedging, nonspeculative purposes</u>.

b. Bonds or other evidences of indebtedness issued, assumed, or guaranteed by the Dominion of Canada, or any province thereof, or by any municipality or district therein, provided that the obligations are valid and legally authorized and issued.

3. Notes secured by mortgages on improved unencumbered real estate, including leaseholds substantially having and furnishing the rights and protection of a first real estate mortgage, within the United States of America or any province of the Dominion of Canada. No loan may be made under this subsection unless at the date of acquisition the total indebtedness secured by such lien shall not exceed seventy-five percent of the value of the property upon which it is a lien. The mortgage loan may be made in an amount exceeding seventy-five percent so long as any amount over seventy-five percent of the value of the property mortgaged is guaranteed or insured by the federal housing administration or guaranteed by the administrator of veteran affairs or is insured by a private mortgage insurance through an insurance company authorized to do business in this state. Loans may be amortized on the basis of a final maturity not exceeding thirty years from the date of the loan with an actual maturity date of the loan at any time less than thirty years. However, a loan on a single-family dwelling where the loan is amortized on the basis of a final maturity twenty-five years or less from the date of the loan may be made in an amount not exceeding eighty percent of the value of the property mortgaged. The loan on a single-family dwelling may be made in an amount exceeding eighty percent so long as any amount over eighty percent of the value of the property mortgaged is insured by private mortgage insurance through an insurance company authorized to do business in this state. Buildings shall not be included in the valuation of such property unless they are insured and the policies are made payable to the company as its interest may appear. In no event shall a loan be made in excess of the amount of insurance carried on the buildings plus the value of the land. No insurance company shall hold less than the entire loan represented by such bonds or notes described in this subsection except that a company may own part of an aggregate obligation if all other participants in the investment are insurance companies authorized to do business in North Dakota or banks whose depositors are insured by the federal deposit insurance corporation or savings and loan associations whose members are insured by the federal savings and loan insurance corporation or unless the security of said bonds or notes, as well as all collateral papers, including insurance policies, executed in connection therewith, are made to and held by a trustee, which trustee shall be a solvent bank or trust company having a paid-in capital of not less than two hundred fifty thousand dollars, except

in case of banks or trust companies incorporated under the laws of the state of North Dakota, wherein a paid-in capital of not less than one hundred thousand dollars shall be required, and that in case of proper notification of default such trustee, upon request of at least twenty-five percent of the holders of the bonds outstanding, and proper indemnification, shall proceed to protect the rights of such bondholders under the provisions of the trust indentures. An insurance company may acquire such an interest in real estate directly or as a joint venture or through a limited or general partnership in which the insurance company is a partner. An insurance company acquiring such an interest in real estate on the basis of a joint venture or through a limited or general partnership may acquire such an interest so long as the company's interest does not exceed seventy-five percent of the value of the property.

4. First mortgage bonds on improved city real estate in any state, issued by a corporation duly incorporated under the laws of any state of the United States of America, if the loans on such real estate are made in accordance with the requirements as to the first mortgage loans set forth in subsection 3.

5. Mortgage bonds and debentures of any solvent railway company duly incorporated and authorized under the laws of this state or of any other state, territory, or insular possession of the United States, or of the Dominion of Canada or of any province thereof.

6. Mortgage bonds and debentures of any solvent industrial public utility or financial corporation duly incorporated and authorized under the laws of the United States of America or of any state, territory, or insular possession thereof, or of the Dominion of Canada or of any province thereof, including rights to purchase or sell the securities or obligations if these rights are traded upon a contract market designated and regulated by a federal agency and purchased for legitimate hedging, nonspeculative purposes.

7. Promissory notes amply secured by the pledge of bonds or other evidences of indebtedness in which the company is authorized to invest its funds by the provisions of this section.

8. Bonds or other evidences of indebtedness issued, assumed, or guaranteed by any instrumentality or agency of the United States of America, including rights to purchase or sell the securities or obligations if these rights are traded upon a contract market designated and regulated by a federal agency and purchased for legitimate hedging, nonspeculatative purposes.

9. a. Savings accounts, under certificates of deposit or in any other form, in solvent banks and trust companies which have qualified for federal deposit insurance corporation protection. Investments in such savings accounts shall not be limited to, or by, the amount of any such insurance protection.

b. Shares and savings accounts, under certificates of deposit or in any other form, in solvent building and loan or savings and loan associations organized under federal law or state law of this or any other state which have qualified for federal savings and loan insurance corporation protection. Investments in such shares and savings accounts shall not be limited to, or by, the amount of any such insurance protection.

c. Shares and deposit accounts, under certificates of deposit or in any other form, in solvent state or federally chartered credit unions which are insured by the national credit union administration. Investments in such shares and deposit accounts shall not be limited to, or by, the amount of any such insurance protection.

d. Short-term or liquidity investments such as certificates of deposit, repurchase agreements, bankers' acceptances, commercial paper, money market mutual funds, or current interest accounts in solvent banks and trust companies, savings and loan associations, state or federally chartered credit unions, investment brokerage houses which are regulated by a federal agency, and such other types of investments as may be deemed appropriate and authorized by rule by the commissioner.

10. Loans made upon the security of its own policies; if a life insurance company, but no loan on any policy shall exceed the reserve value thereof.

11. Preferred stock, of, or common or preferred stock guaranteed as to dividends by, and common stock of, any corporation organized under the laws of the United States, any state, territory, or possession of the United States, the District of Columbia, the Dominion of Canada or any province of the Dominion of Canada, including rights to purchase or sell these securities or obligations if these rights are traded upon a contract market designated and regulated by a federal agency and purchased for legitimate hedging, nonspeculative purposes, subject to the following restrictions and limitations:

a. The company issuing such preferred stock or guaranteeing the dividends on such common stock shall have earned an average amount per annum at least equal

to five percent of the par value of its common and preferred stocks or in the case of stocks having no par value, of its issued or stated value outstanding at the date of purchase, over the period of seven fiscal years immediately preceding the date of purchase or which over such period earned an average amount per annum at least equal to two times the total of its annual interest charges, preferred dividends, and dividends guaranteed by it, determined with reference to the date of purchase.

b. The company issuing any common stock shall have earned an average amount per annum at least equal to six percent of the par value of its capital stock, or in the case of stock having no par value of the issued or stated value of such stock, outstanding at the date of purchase over the period of seven fiscal years immediately preceding the date of purchase.

c. No investments shall be made in any stock authorized under this section if the corporation issuing or guaranteeing the same shall have been in arrears in the payment of dividends thereunder for a period of ninety days within the five-year period immediately preceding purchase of such stock.

d. Investments in preferred, guaranteed, and common stocks shall not exceed in the aggregate ~~ten~~ twenty percent of the life insurance company's admitted assets.

12. Loans, securities, or investments in addition to those permitted in this section, whether or not such loans, securities, or investments qualify or are permitted as legal investments under its charter, or under other provisions of this section or under other provisions of the laws of this state. The aggregate of such company's investments under this subsection shall not at any time exceed five percent of such company's admitted assets, nor more than an amount equal to company's unassigned surplus, whichever be less.

13. Real estate for the production of income or for improvement or development for the production of income subject to the following provisions and limitations:

a. Real estate used primarily for farming or agriculture may not be acquired under the provisions of this subsection.

b. Investments made by any company under the provisions of this subsection shall not at any time exceed ten percent of the admitted assets of the company.

c. An investment in any single parcel of real estate acquired under the provisions of this subsection shall not exceed two percent of the admitted assets of the company.

d. Such real estate, including the cost of improvements, shall be valued at cost and the improvements shall be depreciated annually at an average rate of not less than two percent of the original cost.

e. An insurance company may acquire such real estate or an interest in such real estate directly or as a joint venture or through a limited or general partnership in which the insurance company is a partner.

14. Land and buildings used as home or regional offices, subject to the following provisions and limitations:

a. Land and buildings thereon in which it has its principal office and such other real estate including regional offices as shall be requisite for its convenient accommodation in the transaction of its business.

b. Investments or total commitment in such land and buildings shall not aggregate more than ten percent of the insurer's admitted assets without the consent of the commissioner of insurance.

c. Such real estate, including the cost of improvements, shall be valued at cost and the improvements shall be depreciated annually at an average rate of not less than two percent of the original cost.

15. The commissioner may adopt rules as to investments which are permissible for any domestic insurance company which may waive or increase any limitation on investments or authorize companies to invest their funds in investments which are not specifically mentioned in statutes relating to investments if he finds, after notice and hearing, that such funds would be well invested and available for the payment of losses. The commissioner, in adopting such rules, may not be any more restrictive, or place any greater limitations on, any type of investment in which companies are authorized by statute to invest their funds.

Nothing in this section shall be construed as prohibiting a company from taking any action deemed necessary or expedient for the protection of investments made by it or from accepting in good faith, to protect its interests, securities, or property not herein mentioned in payment or to secure debts due to it.

* SECTION 2. AMENDMENT. Section 26.1-05-19 of the North Dakota Century Code as created by House Bill No. 1054 as approved by

* NOTE: Section 26.1-05-19(26) was also amended by section 2 of Senate Bill No. 2283, chapter 337.

the forty-eighth legislative assembly, is amended and reenacted to read as follows;

26.1-05-19. Authorized investment of funds of insurance companies. A domestic insurance company may invest any of its funds and accumulations in:

1. Securities or obligations made specifically eligible for such investment by law.

2. Bonds or other evidence of indebtedness issued, assumed, or guaranteed by the United States of America, the District of Columbia, or by any state, territory, or insular possession of the United States or by any county, city, township, school district, or other civil division of a state, including those payable from special revenues or earnings specifically pledged for the payment thereof, and those payable from special assessments, including rights to purchase or sell these securities or obligations if these rights are traded upon a contract market designated and regulated by a federal agency and purchased for legitimate hedging, nonspeculative purposes.

3. Bonds or other evidences of indebtedness issued, assumed, or guaranteed by any instrumentality or agency of the United States of America, including rights to purchase or sell these securities or obligations if these rights are traded upon a contract market designated and regulated by a federal agency and purchased for legitimate hedging, nonspeculative purposes.

4. Notes or bonds secured by mortgage or deed of trust insured by the federal housing administrator, debentures issued by the federal housing administrator, and securities issued by national mortgage associations.

5. Bonds issued by the industrial commission under chapter 4-36.

6. Bonds guaranteed by the economic development commission under chapter 6-09.2.

7. Bonds issued by the North Dakota municipal bond bank pursuant to chapter 6-09.4.

8. Bonds issued by the state board of higher education under chapter 15-55.

9. Revenue bonds issued by the state water conservation commission.

10. Interim financing notes issued by the state water conservation commission pursuant to chapter 16-02.

11. Warrants issued by a city under chapter 40-24.

12. Bonds or notes issued pursuant to chapter 40-33.2.

13. Bonds or other obligations issued pursuant to chapter 40-58.

14. Bonds issued under chapter 40-61.

15. Notes or other interest-bearing obligations of any state development corporation of which the company is a member, issued in accordance with chapter 10-30.

16. Bonds or other evidences of indebtedness issued, assumed, or guaranteed by the Dominion of Canada, or any province thereof, or by any municipality or district therein, provided that the obligations are valid and legally authorized and issued.

17. Mortgage bonds and debentures of any solvent railway company duly incorporated and authorized under the laws of this state or of any other state, territory, or insular possession of the United States, or of the Dominion of Canada or of any province thereof.

18. Mortgage bonds and debentures of any solvent industrial~~,~~ public utility~~,~~ or financial corporation duly incorporated and authorized under the laws of the United States of America or of any state, territory, or insular possession thereof, or of the Dominion of Canada or of any province thereof, including rights to purchase or sell these securities or obligations if these rights are traded upon a contract market designated and regulated by a federal agency and purchased for legitimate hedging, nonspeculative purposes.

19. Preferred stock, of, or common or preferred stock guaranteed as to dividends by, and common stock of, any corporation organized under the laws of the United States, any state, territory, or possession of the United States, the District of Columbia, the Dominion of Canada or any province of the Dominion of Canada, including rights to purchase or sell these securities or obligations if these rights are traded upon a contract market designated and regulated by a federal agency and purchased for legitimate hedging, nonspeculative purposes, subject to the following restrictions and limitations:

    a. The company issuing the preferred stock or guaranteeing the dividends on the common stock must have earned an average amount per annum at least equal to five percent of the par value of its common and preferred stocks or in the case of stocks having no par value, of its issued or stated value outstanding

at the date of purchase, over the period of seven fiscal years immediately preceding the date of purchase or which over such period earned an average annual amount at least equal to two times the total of its annual interest charges, preferred dividends, and dividends guaranteed by it, determined with reference to the date of purchase.

b. The company issuing any common stock must have earned an average amount per annum at least equal to six percent of the par value of its capital stock, or in the case of stock having no par value of the issued or stated value of such stock, outstanding at the date of purchase over the period of seven fiscal years immediately preceding the date of purchase.

c. The company issuing or guaranteeing the stock has not been in arrears in the payment of dividends thereunder for a period of ninety days within the five-year period immediately preceding purchase of the stock.

d. Investments in preferred, guaranteed, and common stocks may not exceed in the aggregate ~~ten~~ twenty percent of the life insurance company's admitted assets.

20. Savings accounts, under certificates of deposit or in any other form, in solvent banks and trust companies which have qualified for federal deposit insurance corporation protection, shares and savings accounts, under certificates of deposit, investment certificates, or in any other form, in solvent savings and loan associations organized under federal law or state law of any state which have qualified for federal savings and loan insurance corporation protection, and shares and deposit accounts, under certificates of deposit or in any other form, in solvent state or federally chartered credit unions which are insured by the national credit union administration. Investments in the shares and accounts are not limited to, or by, the amount of any such insurance protection. Short-term or liquidity investments such as certificates of deposit, repurchase agreements, bankers' acceptances, commercial paper, money market mutual funds, or current interest accounts in solvent banks and trust companies, savings and loan associations, state or federally chartered credit unions, investment brokerage houses which are regulated by a federal agency, and such other types of investments as may be deemed appropriate and authorized by rule by the commissioner.

21. Loans made upon the security of its own policies, if a life insurance company, but no loan on any policy may exceed the reserve value thereof.

22. Notes secured by mortgages on improved unemcumbered real estate, including leaseholds substantially having and furnishing the rights and protection of a first real estate mortgage, within the United States of America or any province of the Dominion of Canada. No loan may be made under this subsection unless at the date of acquisition the total indebtedness secured by such lien does not exceed seventy-five percent of the value of the property upon which it is a lien. The loan may be made in an amount exceeding seventy-five percent so long as any amount over seventy-five percent of the value of the property mortgaged is guaranteed or insured by the federal housing administration or guaranteed by the administrator of veterans affairs or is insured by private mortgage insurance through an insurance company authorized to do business in this state. Loans may be amortized on the basis of a final maturity not exceeding thirty years from the date of the loan with an actual maturity date of the loan at any time less than thirty years. A loan on a single-family dwelling where the loan is amortized on the basis of a final maturity twenty-five years or less from the date of the loan may be made in an amount not exceeding eighty percent of the value of the property mortgaged. The loan on a single-family dwelling may be made in an amount exceeding eighty percent so long as any amount over eighty percent of the value of the property mortgaged is insured by private mortgage insurance through an insurance company authorized to do business in this state. Buildings may not be included in the valuation of such property unless they are insured and the policies are made payable to the company as its interest may appear. A loan may not be made in excess of the amount of insurance carried on the buildings plus the value of the land. No insurance company may hold less than the entire loan represented by the bonds or notes described in this subsection except that a company may own part of an aggregate obligation if all other participants in the investment are insurance companies authorized to do business in North Dakota or banks whose depositors are insured by the federal deposit insurance corporation or savings and loan associations whose members are insured by the federal savings and loan insurance corporation or unless the security of the bonds or notes, as well as all collateral papers, including insurance policies, executed in connection therewith, are made to and held by a trustee which is a solvent bank or trust company having a paid-in capital of not less than two hundred fifty thousand dollars, except in case of banks or trust companies incorporated under the laws of the state of North Dakota, wherein a paid-in capital of not less than one hundred thousand dollars is required. In case of proper notification of default, the trustee, upon request of at least twenty-five percent of the holders of the bonds outstanding, and proper indemnification, shall proceed to

protect the rights of the bondholders under the provisions of the trust indentures. An insurance company may acquire such an interest in real estate directly or as a joint venture or through a limited or general partnership in which the insurance company is a partner. An insurance company acquiring such an interest in real estate on the basis of a joint venture or through a limited or general partnership may acquire such an interest so long as the company's interest does not exceed seventy-five percent of the value of the property.

23. First mortgage bonds on improved city real estate in any state, issued by a corporation duly incorporated under the laws of any state of the United States of America, if the loans on the real estate are made in accordance with the requirements as to first mortgage loans in subsection 22.

24. Real estate for the production of income or for improvement or development for the production of income subject to the following provisions and limitations:

a. Real estate used primarily for farming or agriculture may not be acquired under this subsection.

b. Investments made by any company under this subsection may not at any time exceed ten percent of the admitted assets of the company.

c. An investment in any single parcel of real estate acquired under this subsection may not exceed two percent of the admitted assets of the company.

d. The real estate, including the cost of improvements, must be valued at cost and the improvements may be depreciated annually at an average rate of not less than two percent of the original cost.

e. An insurance company may acquire such real estate or an interest in such real estate directly or as a joint venture or through a limited or general partnership in which the insurance company is a partner.

25. Land and buildings used as home or regional offices, subject to the following provisions and limitations:

a. Land and buildings thereon in which it has its principal office and any other real estate including regional offices requisite for its convenient accommodation in the transaction of its business.

b. Investments or total commitment in the land and buildings may not aggregate more than ten percent of the company's admitted assets without the consent of the commissioner.

c. The real estate, including the cost of improvements, must be valued at cost and the improvements must be depreciated annually at an average rate of not less than two percent of the original cost.

26. Investments by loans or otherwise, in the purchase of electric or mechanical machines constituting a data processing system. The company may hold the system as an admitted asset for use in connection with the business of the company if, (a) its aggregate cost does not exceed five percent of the admitted assets of the company; (b) the cost of the component machines constituting the system is fully amortized over a period of not to exceed ten years. If a data processing system consists of separate component machines acquired at different times, then the cost of each component must be amortized over a period not to exceed ten years commencing with the date of acquisition of each component.

27. Promissory notes amply secured by the pledge of bonds or other evidences of indebtedness in which the company is authorized to invest its funds by the provisions of this section.

28. Loans, securities, or investments in addition to those permitted in this section, whether or not the loans, securities, or investments qualify or are permitted as legal investments under its charter, or under other provisions of this section or under other provisions of the laws of this state. The aggregate of such company's investments under this subsection may not exceed either five percent of the company's admitted assets, or the amount equal to the company's unassigned surplus, whichever is less.

29. The commissioner may adopt rules as to investments which are permissible for any domestic insurance company which may waive or increase any limitation on investments or authorize companies to invest their funds in investments which are not specifically mentioned in statutes relating to investments if he finds, after notice and hearing, that such funds would be well invested and available for the payment of losses. The commissioner, in adopting such rules, shall not be any more restrictive, or place any greater limitations on, any type of investment in which companies are authorized by statute to invest their funds.

This section does not prohibit a company from taking any action deemed necessary or expedient for the protection of investments made by it or from accepting in good faith, to protect its interests, securities, or property not mentioned in this section in payment or to secure debts due to it.

Approved March 15, 1983

CHAPTER 339

HOUSE BILL NO. 1225
(Committee on Industry, Business, and Labor)
(At the request of the Commissioner of Insurance)

HEALTH CARE BENEFIT PROVIDER JURISDICTION

AN ACT to authorize the commissioner of insurance to determine jurisdiction of providers of health care benefits.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. Jurisdiction over providers of health care benefits. Notwithstanding any other provision of law, and except as provided herein, any person or other entity, other than an insurance company duly licensed in this or another state which provides coverage in this state for medical, surgical, chiropractic, physical therapy, speech pathology, audiology, professional mental health, dental, hospital, or optometric expenses, whether such coverage is by direct payment, reimbursement, or otherwise, shall be presumed to be subject to the jurisdiction of the commissioner of insurance unless the person or other entity show that while providing such services it is subject to the jurisdiction of another agency of this state, any subdivisions thereof, or the federal government.

SECTION 2. How to show jurisdiction. A person or entity may show that it is subject to the jurisdiciton of another agency of this state, any subdivision thereof, or the federal government by providing to the commissioner the appropriate certificate, license, or other document issued by the other governmental agency which permits or qualifies it to provide those services.

SECTION 3. Examination. Any person or entity which is unable to show that it is subject to the jurisdiction of another agency of this state, any subdivision thereof, or the federal government, shall submit to an examination by the commissioner to determine the organization and solvency of the person or the entity, and to determine whether or not such person or entity is in compliance with the applicable provisions of state law.

SECTION 4. Subject to state laws. Any person or entity unable to show that it is subject to the jurisdiction of another agency of this state, any subdivision thereof, or the federal government shall

be subject to all appropriate provisions of state law regarding the conduct of its business.

SECTION 5. Disclosure. Any production agency or administrator which advertises, sells, transacts, or administers coverage in this state described in section 1 which is provided by any person or entity described in section 3 shall, if that coverage is not fully insured or otherwise fully covered by an admitted life or disability insurer, nonprofit hospital service plan, or nonprofit health care plan, advise any purchaser, prospective purchaser, and covered person of such lack of insurance or other coverage.

Any administrator which advertises or administers coverage in this state, described in section 1, which is provided by any person or entity described in section 3, shall advise any production agency of the elements of the coverage including the amount of "stop-loss" insurance in effect.

Approved March 10, 1983

CHAPTER 340

HOUSE BILL NO. 1068
(Legislative Council)
(Interim Social Services Committee)

COMPREHENSIVE HEALTH INSURANCE PLAN

AN ACT to create and enact a new paragraph to subdivision d of subsection 1 of section 26-16.1-03, a new paragraph to subdivision d of subsection 1 of section 26-16.1-04, section 26-16.1-04.1, and a new section to chapter 57-38 of the North Dakota Century Code, or in the alternative if House Bill No. 1054 is approved by the forty-eighth legislative assembly, a new paragraph to subdivision d of subsection 1 of section 26.1-08-05, a new paragraph to subdivision d of subsection 1 of section 26.1-08-06, section 26.1-08-06.1, and a new section to chapter 57-38 of the North Dakota Century Code, relating to elimination of coverage for experimental medical and surgical procedures, maximum benefits of a qualified medicare extended plan, and an income tax credit for comprehensive health association assessments; to amend and reenact section 26-01-11, subsection 12 of section 26-16.1-01, section 26-16.1-05, subsection 2 of section 26-16.1-07, subsection 4 of section 26-16.1-08, section 26-16.1-09, and subsection 4 of section 26-16.1-11 of the North Dakota Century Code, or in the alternative if House Bill No. 1054 is approved by the forty-eighth legislative assembly, section 26.1-03-17, subsection 10 of section 26.1-08-01, subsection 2 of section 26.1-08-03, sections 26.1-08-04 and 26.1-08-08, subsection 4 of section 26.1-08-09, and subsection 4 of section 26.1-08-12 of the North Dakota Century Code, relating to a premium tax credit for comprehensive health association assessments, to the definition of qualified plan, to limiting association premiums to one hundred thirty-five percent of established rates, to the payment of claim expenses in excess of premiums allocated for the payment of benefits, to the maximum benefits of the comprehensive health insurance plan, and to a waiting period; to repeal subsection 3 of section 26-16.1-07 of the North Dakota Century Code, or in the alternative if House Bill No. 1054 is approved by the forty-eighth legislative assembly to repeal subsection 3 of section 26.1-08-03 of the North Dakota Century Code, relating to contracts of reinsurance; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. AMENDMENT. If House Bill No. 1054 does not become effective, section 26-01-11 of the 1981 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-01-11. Commissioner of insurance to collect premium tax - Insurance companies generally - Domestic fire insurance companies - Computation. Before issuing the annual certificate required by law, the commissioner of insurance shall collect the following annual taxes from insurance companies doing business within the state:

1. From every insurance company doing business in this state except stock and mutual companies organized under the laws of this state, a tax equal in amount to two and one-half percent of the gross amount of premiums, membership fees, and policy fees received in this state during the preceding year, such tax to be payable at the time when the annual statement of business required by law is filed; provided, however, that this tax shall not apply to considerations for annuities.

2. From every domestic fire insurance company, whether mutual, stock, or otherwise, a tax upon its fire insurance premiums or assessments, or both, equal to one-half of one percent of the gross premiums and assessments, less return premiums on all direct business received by it, or by its agent for it, in cash or otherwise in this state. Such tax shall be collected for the purpose of assisting in the maintenance of the fire marshal's department and shall be payable on or before March first in each year.

The amount of any assessment paid by any member of a comprehensive health association under subsection 4 of section 26-16.1-08 is a credit against the premium and income tax for which the member may be liable for the year in which the assessment was paid.

SECTION 2. AMENDMENT. If House Bill No. 1054 does not become effective, subsection 12 of section 26-16.1-01 of the 1981 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

12. "Qualified plan" means those health benefit plans which have been certified by the commissioner as providing the minimum benefits required by section 26-16.1-03 ~~or~~, 26-16.1-04, or 26-16.1-04.1 or the actuarial equivalent of those benefits.

SECTION 3. If House Bill No. 1054 does not become effective, a new paragraph to subdivision d of subsection 1 of section 26-16.1-03 of the 1981 Supplement to the North Dakota Century Code is hereby created and enacted to read as follows:

Any charge for organ transplants unless prior approval is received from the board of directors of the comprehensive health association.

SECTION 4. If House Bill No. 1054 does not become effective, a new paragraph to subdivision d of subsection 1 of section 26-16.1-04 of the 1981 Supplement to the North Dakota Century Code is hereby created and enacted to read as follows:

Any charge for organ transplants unless prior approval is received from the board of directors of the comprehensive health association.

SECTION 5. If House Bill No. 1054 does not become effective, section 26-16.1-04.1 of the North Dakota Century Code is hereby created and enacted to read as follows:

26-16.1-04.1. Minimum benefits of a qualified medicare extended plan. A qualified plan of health coverage must be established for eligible persons who are enrolled under title 1, part 1 of Public Law 89-97 and amendments thereto (Health Insurance for the Aged Act), known as medicare. The plan of health care coverage must supplement medicare part A and medicare part B and must provide for benefits consisting of that portion of medicare eligible expenses which are not paid by medicare part A and medicare part B. The plan of health coverage must provide benefits for medicare deductible and coinsurance amounts for medicare eligible expenses to the extent recognized as reasonable by medicare part A and medicare part B. No benefits may be provided for expenses that are not medicare eligible expenses.

SECTION 6. AMENDMENT. If House Bill No. 1054 does not become effective, section 26-16.1-05 of the 1981 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-16.1-05. Association plan premium. The schedule of premiums to be charged eligible persons for membership in the comprehensive health insurance plan shall be ~~designed to be self-supporting and based on generally accepted actuarial principles~~ established by the association but may not exceed one hundred thirty-five percent of the average premium rates charged by the five largest insurers with the largest individual qualified plan of insurance in force in this state. The premium rates of the five insurers used to establish the premium rates for each type of coverage offered by the association shall be determined by the commissioner from information provided by all insurers annually at the request of the commissioner. The information requested must include the number of qualified plans or actuarial equivalent plans offered by each insurer and the rates charged by the insurer for each type of plan offered by the insurer and any other information as the commissioner considers as necessary. The commissioner shall utilize generally acceptable actuarial principles and structurally compatible rates.

SECTION 7. AMENDMENT. If House Bill No. 1054 does not become effective, subsection 2 of section 26-16.1-07 of the 1981 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

2. The board of directors of the association shall be made up of ten individuals, one from each of the ten participating member insurers of the association with the highest annual premium volumes of accident and sickness insurance contracts as determined in subsection 1. Each board member shall be entitled to votes, in person or by proxy, based on the member's annual premium volume of accident and sickness insurance contracts as determined in subsection 1, in accordance with the following schedule:

$ 100,000	- 4,999,999	1 vote
$ 5,000,000	- 9,999,999	2 votes
$10,000,000	- 14,999,999	3 votes
$15,000,000 or more		4 votes

Members of the board may be reimbursed from the moneys of the association for expenses incurred by them due to their service as board members, but shall not otherwise be compensated by the association for their services. The costs of conducting the meetings of the association and its board of directors shall be borne by participating members of the association in accordance with subsection 4 of section 26-16.1-08.

SECTION 8. AMENDMENT. If House Bill No. 1054 does not become effective, subsection 4 of section 26-16.1-08 of the 1981 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

4. Each participating member of the association which is liable for state income tax or state premium tax shall share the losses due to claims expenses and meeting expenses under subsection 2 of section 26-16.1-07 of the comprehensive health insurance plan ~~pursuant to the terms of individual reinsurance contracts executed by the association with each participating member in accordance with section 26-16.1-07.~~ Deviations in. The difference between the total claims expense of the association plan ~~from~~ and the premium payments allocated to the payment of benefits ~~shall~~ be is the liability of those association members that are liable for state income tax or state premium tax. ~~Association~~ Such association members shall share in the excess costs of the association plan in an amount equal to the ratio of a member's total annual premium volume for accident and sickness insurance charges, received from or on behalf of state residents, to the total accident and sickness insurance premium contract charges received by ~~all~~ association members that are liable for state income taxes or state premium taxes from

or on behalf of state residents, as determined by the commissioner. ~~The reinsurance contracts shall provide for a retroactive determination of each~~ Each member's liability may be determined retroactively and payment of the assessment shall be due within thirty days after ~~each renewal date of the reinsurance contract~~ notice of the assessment is given. Failure by a member to tender to the association the full amount assessed ~~reinsurance payments~~ within thirty days of notification by the association shall be grounds for termination of membership.

SECTION 9. AMENDMENT. If House Bill No. 1054 does not become effective, section 26-16.1-09 of the 1981 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-16.1-09. Minimum benefits of comprehensive health insurance plan. The association through its comprehensive health insurance plan shall offer policies which provide at least the benefits of a number one, two, and three qualified plan A and qualified plan B and a qualified medicare extended plan.

SECTION 10. AMENDMENT. If House Bill No. 1054 does not become effective, subsection 4 of section 26-16.1-11 of the 1981 Supplement to the North Dakota Century Code is hereby amended and reenacted to read as follows:

4. No person who obtains coverage pursuant to this section shall be covered for any preexisting condition during the first six months of coverage under the association plan if the person was diagnosed or treated for that condition during the ninety days immediately preceding the filing of an application. However, this subsection does not apply to a person who has had continuous coverage under an individual, a family, or group accident and sickness insurance policy during the year immediately preceding the filing of an application for nonelective procedures.

SECTION 11. If House Bill No. 1054 does not become effective, a new section to chapter 57-38 of the North Dakota Century Code is hereby created and enacted to read as follows:

Income tax credit for comprehensive health association assessments. The amount of any assessment paid by any member of the comprehensive health association under subsection 4 of section 26-16.1-08 is a credit against the state income tax for which a member may be liable for the year which the assessment was paid.

SECTION 12. AMENDMENT. Section 26.1-03-17 of the North Dakota Century Code as created by House Bill No. 1054, as approved by the forty-eighth legislative assembly, is hereby amended and reenacted to read as follows:

26.1-03-17. Commissioner to collect premium tax - Insurance companies generally - Domestic fire companies - Computation. Before issuing the annual certificate required by law, the commissioner shall collect the following annual taxes from insurance companies doing business within the state:

1. From every insurance company doing business in this state except stock and mutual companies organized under the laws of this state, a tax equal in amount to two and one-half percent of the gross amount of premiums, membership fees, and policy fees received in this state during the preceding year. This tax shall not apply to considerations for annuities. The tax is payable at the time when the annual statement of business required by law is filed.

2. From every domestic fire insurance company, whether mutual, stock, or otherwise, a tax upon its fire insurance premiums or assessments, or both, equal to one-half of one percent of the gross premiums and assessments, less return premiums on all direct business received by it, or by its agent for it, in cash or otherwise in this state. The tax is collected for the purpose of assisting in the maintenance of the fire marshal's department and is payable on or before March first of each year.

The amount of any assessment paid by any member of a comprehensive health association under subsection 4 of section 26.1-08-09 is a credit against the premium tax for which the member may be liable for the year in which the assessment was paid.

SECTION 13. AMENDMENT. Subsection 10 of section 26.1-08-01 of the North Dakota Century Code as created by House Bill No. 1054, as approved by the forty-eighth legislative assembly, is hereby amended and reenacted to read as follows:

10. "Qualified plan" means those health benefit plans certified by the commissioner as providing the minimum benefits required by section 26.1-08-05 ~~or~~, 26.1-08-06, or 26.1-08-06.1 or the actuarial equivalent of those benefits.

SECTION 14. AMENDMENT. Subsection 2 of section 26.1-08-03 of the North Dakota Century Code as created by House Bill No. 1054, as approved by the forty-eighth legislative assembly, is hereby amended and reenacted to read as follows:

2. The board of directors of the association must consist of ten individuals, one from each of the ten participating member insurance companies of the association with the highest annual premium volumes of accident and sickness insurance contracts as determined in subsection 1. Each board member is entitled to votes, in person or by proxy, based on the member's annual premium volume of accident

and sickness insurance contracts as determined in subsection 1, in accordance with the following schedule:

$ 100,000	- 4,999,999	1 vote
$ 5,000,000	- 9,999,999	2 votes
$10,000,000	- 14,999,999	3 votes
$15,000,000 or more		4 votes

Members of the board may be reimbursed from the moneys of the association for expenses incurred by them due to their service as board members, but may not otherwise be compensated by the association for their services. The costs of conducting the meetings of the association and its board of directors must be borne by participating members of the association in accordance with subsection 4 of section 26.1-08-09.

SECTION 15. AMENDMENT. Section 26.1-08-04 of the North Dakota Century Code as created by House Bill No. 1054, as approved by the forty-eighth legislative assembly, is hereby amended and reenacted to read as follows:

26.1-08-04. Minimum benefits of association plan. The association through its plan must offer policies which provide at least the benefits of a number one, two, and three qualified plan A and qualified plan B and a qualified medicare extended plan.

SECTION 16. A new paragraph to subdivision d of subsection 1 of section 26.1-08-05 of the North Dakota Century Code as created by House Bill No. 1054, as approved by the forty-eighth legislative assembly, is hereby created and enacted to read as follows:

Any charge for organ transplants unless prior approval is received from the board of directors of the comprehensive health association.

SECTION 17. A new paragraph to subdivision d of subsection 1 of section 26.1-08-06 of the North Dakota Century Code as created by House Bill No. 1054, as approved by the forty-eighth legislative assembly, is hereby created and enacted to read as follows:

Any charge for organ transplants unless prior approval is received from the board of directors of the comprehensive health association.

SECTION 18. Section 26.1-08-06.1 of the North Dakota Century Code as created by House Bill No. 1054, as approved by the forty-eighth legislative assembly, is hereby created and enacted to read as follows:

26.1-08-06.1. Minimum benefits of a qualified medicare extended plan. A qualified plan of health coverage must be established for eligible persons who are enrolled under title 1, part 1 of Public Law 89-97 and amendments thereto (Health Insurance

for the Aged Act), known as medicare. The plan of health care coverage must supplement medicare part A and medicare part B and must provide for benefits consisting of that portion of medicare eligible expenses which are not paid by medicare part A and medicare part B. The plan of health coverage must provide benefits for medicare deductible and coinsurance amounts for medicare eligible expenses to the extent recognized as reasonable by medicare part A and medicare part B. No benefits may be provided for expenses that are not medicare eligible expenses.

SECTION 19. AMENDMENT. Section 26.1-08-08 of the North Dakota Century Code as created by House Bill No. 1054, as approved by the forty-eighth legislative assembly, is hereby amended and reenacted to read as follows:

26.1-08-08. Association plan premium. The schedule of premiums to be charged eligible persons for membership in the association plan must be ~~designed to be self-supporting and based on generally accepted actuarial principles~~ established by the association but may not exceed one hundred thirty-five percent of the average premium rates charged by the five largest insurers with the largest individual qualified plan of insurance in force in this state. The premium rates of the five insurers used to establish the premium rates for each type of coverage offered by the association shall be determined by the commissioner from information provided by all insurers annually at the request of the commissioner. The information requested must include the number of qualified plans or actuarial equivalent plans offered by each insurer and the rates charged by the insurer for each type of plan offered by the insurer and any other information as the commissioner considers as necessary. The commissioner shall utilize generally acceptable actuarial principles and structurally compatible rates.

SECTION 20. AMENDMENT. Subsection 4 of section 26.1-08-09 as created by House Bill No. 1054, as approved by the forty-eighth legislative assembly, is hereby amended and reenacted to read as follows:

4. Each participating member of the association which is liable for state income tax or state premium tax must share the losses due to claims expenses and meeting expenses under subsection 2 of 26.1-08-03 of the association plan ~~pursuant to the terms of individual reinsurance contracts executed by the association with each participating member in accordance with section 26.1-08-03. Any deviation in~~. The difference between the total claims expense of the association plan ~~from~~ and the premium payments allocated to the payment of benefits is the liability of those association members that are liable for state income tax or state premium tax. ~~Association~~ Such association members must share in the excess costs of the association plan in an amount equal to the ratio of a member's total annual premium volume for accident and sickness insurance charges, received from or on behalf of

state residents, to the total accident and sickness insurance premium contract charges received by ~~all~~ association members that are liable for state income taxes or state premium taxes from or on behalf of state residents, as determined by the commissioner. ~~The reinsurance contracts must provide for a retroactive determination of each~~ Each member's liability may be determined retroactively and payment of the assessment is due within thirty days after ~~each renewal date of the reinsurance contract~~ notice of the assessment is given. Failure by a member to tender to the association the full amount assessed ~~reinsurance payments~~ within thirty days of notification by the association is grounds for termination of membership.

SECTION 21. AMENDMENT. Subsection 4 of section 26.1-08-12 of the North Dakota Century Code as created by House Bill No. 1054, as approved by the forty-eighth legislative assembly, is hereby amended and reenacted to read as follows:

4. A person who obtains coverage pursuant to this section may not be covered for any preexisting condition during the first six months of coverage under the association plan if the person was diagnosed or treated for that condition during the ninety days immediately preceding the filing of an application. This subsection does not apply to a person who has had continuous coverage under an individual, a family, or group policy during the year immediately preceding the filing of an application for nonelective procedures.

SECTION 22. If House Bill No. 1054 becomes effective, a new section to chapter 57-38 of the North Dakota Century Code is hereby created and enacted to read as follows:

Income tax credit for comprehensive health association assessments. The amount of any assessment paid by any member of the comprehensive health association under subsection 4 of section 26.1-08-09 is a credit against the state income tax for which a member may be liable for the year which the assessment was paid.

SECTION 23. REPEAL. If House Bill No. 1054 does not become effective, subsection 3 of section 26-16.1-07 of the 1981 Supplement to the North Dakota Century Code is hereby repealed.

SECTION 24. REPEAL. If House Bill No. 1054 does become effective, subsection 3 of section 26.1-08-03 of the North Dakota Century Code is hereby repealed.

SECTION 25. EMERGENCY. This Act is hereby declared to be an emergency measure and shall be in effect from and after its passage and approval.

Approved March 21, 1983

CHAPTER 341

SENATE BILL NO. 2231
(Committee on Industry, Business, and Labor)
(At the request of the Commissioner of Insurance)

STATE BONDING FUND

AN ACT to establish a state bonding fund; to repeal chapter 26-23 of the North Dakota Century Code, relating to the state bonding fund, or in the alternative, to repeal chapter 26.1-21 of the North Dakota Century Code, as created by House Bill No. 1054, as approved by the forty-eighth legislative assembly, relating to the state bonding fund.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. Definitions. In this chapter, unless the context or subject matter otherwise requires:

1. "Blanket bond" means a bond which covers collectively all public employees and public officials without the necessity of scheduling names or positions as a part of the bond, and a bond whereby new public employees and new public officials entering employment or office during the period of the bond are automatically included without notice to the fund.

2. "Commissioner" means the commissioner of insurance.

3. "Fund" means the state bonding fund.

4. "Political subdivision" means a county, city, township, school district or park district, or any other unit of local government.

5. "Public employee" means and includes any and all persons employed by the state or any of its political subdivisions, officers and employees eligible under section 57-15-56, and employees under section 61-16.1-05 except for persons employed by the occupational and professional boards and commissions under title 43, and by the state bar association.

6. "Public official" means any officer or deputy, either elected or appointed, of the state or any of its political subdivisions who is required to be bonded by any law of this state, except for officers of the occupational and professional boards and commissions under title 43, and of the state bar association.

7. "State" means state departments, agencies, industries, and institutions.

SECTION 2. State bonding fund under management of commissioner. The commissioner shall manage the fund. The fund shall be maintained as a fund for the bonding of public employees and public officials. All moneys collected under this chapter shall be paid into such fund.

SECTION 3. Commissioner may employ assistants. The commissioner may employ such clerical and other assistants as may be necessary to operate the fund. The salaries of all employees together with all other expenditures for the operation of the fund shall remain within the appropriations made from time to time by the legislative assembly for such purposes and shall be paid by warrant-check drawn on the state treasury prepared by the office of management and budget after the approval of expense vouchers by the office of the budget.

SECTION 4. Attorney general is attorney for fund. The attorney general shall act as attorney for the commissioner in any and all actions and proceedings to which the commissioner is a party on behalf of the fund.

SECTION 5. Investment of fund. Investment of the fund is under the supervision of the state investment board in accordance with chapter 21-10.

SECTION 6. Condition of bond created by chapter - Limitation. The condition of the blanket bond, arising under the provisions of this chapter shall be limited to that of a fidelity bond and shall provide that the public employee or public official, as principal, shall render a true account of all moneys and property of every kind that come into his hands as such public employee or public official, and shall pay over and deliver the same according to law.

SECTION 7. Coverage. The amount of coverage afforded to each state agency, department, industry, and institution shall be determined by the commissioner based upon the amount of money or property handled and the opportunity for defalcation. The coverage may be greater than but not less than the amount required by law for such positions.

SECTION 8. Review of public official and employee bond coverage. Each state agency, department, industry, and institution shall annually review the amount of blanket bond coverage of its officers and employees. When conducting an audit examination of such state

agencies, departments, industries, and institutions, the state auditor shall evaluate the blanket bond coverage and, if deemed necessary, shall include recommendations for changes in the amount of that coverage in the auditor's report.

SECTION 9. Premiums - Amount to whom paid - Minimum. The premium for a blanket bond shall be determined by the commissioner. Premiums shall be paid in advance by the proper authority of the state, or of the political subdivision of the state, from its treasury, to the state treasurer who shall keep the same in the fund. The state treasurer shall issue quadruple receipts therefor. The treasurer shall file one of such receipts in the treasurer's office, and shall mail one to the official making such payment, one to the commissioner, and one to the state auditor. The minimum premium for each bond shall be two dollars and fifty cents per year. Payments shall be made for one year or for such longer terms as the commissioner may prescribe. From and after July 1, 1953, the premiums referred to in this section shall be waived until the reserve fund of the state bonding fund shall have been depleted below the sum of two and one-half million dollars. The collection of premiums shall be resumed on the bonds, at the rates herein set forth, whenever the reserve fund shall be depleted below the sum of two and one-half million dollars. The premiums shall continue to be collected until the reserve fund shall reach a total of three million dollars, at which time all premiums shall again be waived until the reserve fund has been depleted below the sum of two and one-half million dollars.

SECTION 10. Automatic insurance of state and political subdivisions. The public employees and public officials of the state and each political subdivision thereof, as the case may be, shall be insured in the fund according to the provisions of this chapter upon application to the state bonding fund and upon approval by the commissioner. Unless an application is denied within sixty days from the date it is received by the state bonding fund, the application will be deemed approved and bond coverage in force. The provisions of this chapter and of any statute requiring a bond shall constitute the bond of each and every public official for the purpose of any law of this state requiring such bond and shall constitute the entire contract between the fund and the state or its political subdivisions, respectively, as the obligee in any such bond.

SECTION 11. Default of public employees or public officials - Duty of public officer - Limitation on filing of claims against fund. Immediately upon, and in no event later than sixty days after, the discovery of any default or wrongful act on the part of any public employee or public official, for which the fund is or may become liable, the state auditor, county auditor, city auditor, township clerk, or school district clerk, or the treasurer of the state or subdivision thereof, if the defaulting officer is the auditor or clerk of the state or political subdivision, and any other officer having supervision of a defaulting public employee or public official, shall file a claim with the commissioner against the fund. Any

person injured by such default or wrongful act, if that person intends to hold the fund liable therefor, must present the claim to the commissioner within sixty days after the discovery of such default or wrongful act. If a claim is not filed within the time limited by this section, such claim is waived. A claim filed under the provisions of this section shall contain an abstract of the facts upon which it is based and shall be verified by the claimant or by someone in the claimant's behalf, and, together with all papers relating thereto, shall remain on file with the commissioner.

SECTION 12. **Commissioner to notify state auditor of default of public employee or public official - Duty of state auditor.** If any public employee or public official shall default or create a liability against the fund, the commissioner shall notify the state auditor, who immediately shall check the accounts of such public employee or public official and file a report with the commissioner stating the amount, if any, due from the fund because of such default or wrongful act. For such service, the auditor shall be paid out of the fund the same fees as the auditor is paid for auditing the accounts of county officers.

SECTION 13. **Audit of claims against state bonding fund - Register of claims.** All liability claims against the fund shall be audited by the commissioner, and such audit shall be approved by the attorney general. The commissioner shall have the authority to prescribe the forms upon which claims shall be presented, and may administer oaths and examine witnesses in connection with claims presented to him. If the commissioner, with the approval of the attorney general, shall find a claim or any part thereof to be a valid, just, and proper charge against the fund, the commissioner shall make and file an order to that effect and state therein the amount allowed upon the claim. A brief description of every claim filed against the fund shall be entered by the commissioner in a register provided for that purpose showing the name of the claimant, the amount and character of the claim, the action taken upon the claim, and the date when such action was taken.

SECTION 14. **Filing claim is condition precedent to bringing action - Failure to act is refusal.** No action may be maintained against the fund upon any claim whatever until the claim first has been presented for allowance as provided in this chapter and the allowance of such claim has been refused. Any claim which has not been acted upon and allowed or disallowed within sixty days after its presentation for allowance shall be deemed to be refused. The filing and disallowance of the claim must be alleged in the complaint in any action brought thereon against the fund.

SECTION 15. **Limitation of time for bringing action against the fund.** No action may be maintained against the fund upon any claim whatever unless such action is commenced within one year after filing of the claim with the commissioner.

SECTION 16. **Suit by party injured by default of public employee or public official - Subrogation - Right of appeal.** Any person or corporation

injured by the default or wrongful act of any public employee or public official may sue the public employee or public official and to effect recovery from the fund must join the fund as codefendant. A judgment must be obtained against the public employee or public official to create liability upon the bond. If the judgment is obtained against the public employee or public official, it must specify that to the extent to which the fund is liable upon the bond of the public employee or public official, the judgment shall be paid out of any money in the fund or that which may accrue to the fund. If the judgment is paid out of the fund, the fund has a right to recover and is subrogated to the right of the judgment creditor to recover against such public employee or public official. In all proceedings to enforce such right of subrogation, the commissioner shall act for and in behalf of the fund, and in any action or proceeding the commissioner may appeal from any appealable order or from any judgment against the fund the same as other parties to civil actions may appeal.

SECTION 17. Allowed liability claims payable from fund - Administrative expenses - Methods of payment. All liability claims which are allowed against the fund shall be paid upon warrants drawn upon the state treasurer against the fund. Such warrants shall be prepared by the office of management and budget pursuant to the directions of the commissioner. Payments for administrative expenses of the state bonding fund shall be made within the limitations of legislative appropriations upon warrant-checks prepared by the office of management and budget after the approval of vouchers by the commissioner.

SECTION 18. Commissioner may make examinations - Request for accounting - Reporting defaulting official to governor. If the commissioner is of the opinion at any time that the interests of the fund are jeopardized by the misconduct or inefficiency of any public official, the commissioner shall make, or request the state auditor to make, an examination, and, if necessary, shall cause an action for an accounting to be instituted against such public official for the purpose of requiring a complete disclosure of the business of the office of which such public official is an incumbent. Such action shall be brought in the name of the commissioner as plaintiff, and the court in such action may interplead all parties concerned. Whenever the commissioner deems it advisable, the commissioner shall make a complaint to the governor requesting the governor to institute an investigation with the purpose of removing from the office any defaulting public official or any public official who so conducts the affairs of his office as to endanger the fund.

SECTION 19. Cancellation of liability of fund - When permitted - Effect. The commissioner, after due investigation and if in the commissioner's judgment the interests of the fund require, may cancel the liability of the fund for the acts of any public employee or public official, such cancellation to take effect thirty days after written notice thereof. In such case, the public official whose bond is canceled, or the public employee whose coverage is

canceled under a blanket bond, may secure, at his own expense, a bond executed by a duly authorized surety company.

SECTION 20. Notice of cancellation - Right to appeal from cancellation - Procedure. The commissioner shall notify the public employee or public official immediately by registered or certified mail when his bond, or coverage under a blanket bond, is ordered canceled, and the public employee or public official shall have twenty days after the receipt of such notice within which to take an appeal from the decision of the commissioner to the district court of the judicial district in which the public employee or public official resides. The court shall hear such appeal at a day to be fixed by the judge thereof not less than ten days nor more than thirty days after the filing of the appeal with the clerk. Notice of such appeal shall be served by the appellant upon the commissioner. The case shall be tried by the court without a jury.

SECTION 21. Fund may reinsure risks - Premium on reinsurance. The commissioner may reinsure any part of any liability in excess of twenty-five thousand dollars upon any one public official, or group of public officials and public employees under a blanket bond, at a cost not exceeding the rate of premium provided for in this chapter, and the expense of such reinsurance shall be paid out of the fund.

SECTION 22. Publication of statement of fund - Biennial report to governor and office of management and budget. The commissioner, on or about the first day of December in each year after the regular session of the legislative assembly, shall publish in four newspapers of federal circulation within the state a copy of the statement of the commissioner's work and of the condition of the fund during the two preceding fiscal years. The commissioner shall submit a biennial report as prescribed by section 54-06-04 to the governor and to the office of management and budget.

SECTION 23. Public official may furnish private bond - Premiums payable from public moneys only to fund. Any person elected or appointed to office, in lieu of the bond provided for in this chapter, may furnish a bond issued by a duly authorized surety company, but no officer or board of the state or of any political subdivision shall pay for any such bond or bonds out of any public funds.

SECTION 24. REPEAL. If House Bill No. 1054 does not become effective, chapter 26-23 of the North Dakota Century Code is hereby repealed.

SECTION 25. REPEAL. Chapter 26.1-21 of the North Dakota Century Code as created by House Bill No. 1054, as approved by the forty-eighth legislative assembly, is hereby repealed.

Approved March 4, 1983

CHAPTER 342

HOUSE BILL NO. 1411
(Rued)

PREMIUM RETURN TO INSURED

AN ACT to amend and reenact section 26-04-03 of the North Dakota Century Code, or in the alternative to amend and reenact section 26.1-24-03 of the North Dakota Century Code as created by House Bill No. 1054, as approved by the forty-eighth legislative assembly, relating to when an insured is entitled to a return of premium.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. AMENDMENT. If House Bill No. 1054 does not become effective, section 26-04-03 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26-04-03. When insured entitled to return of premium. A person insured is entitled to a return of premium, including all policy fees in excess of two dollars, on any one policy, and all other sums of money paid in consideration of the policy of insurance, as follows:

1. To the whole of such premium, fee, or other sums if no part of his interest in the thing insured is exposed to any of the perils insured against.

2. To the whole of the premium when the contract is voidable on account of the fraud or misrepresentation of the insurer or on account of facts of the existence of which the insured was ignorant without his fault, or when by any default of the insured other than actual fraud, the insurer never incurred any liability under the policy.

3. ~~When~~ Except as provided for in a policy form filed with and approved by the commissioner, when insurance other than life is made for a definite period of time and the insured surrenders his policy, to such proportion of such premium, fee, or other sum as corresponds with the unexpired time upon the amount of the policy remaining after deducting therefrom any claim for loss or damage under the policy which has accrued previously.

SECTION 2. AMENDMENT. Section 26.1-24-03 of the North Dakota Century Code as created by House Bill No. 1054, as approved by the forty-eighth legislative assembly, of the North Dakota Century Code is hereby amended and reenacted to read as follows:

26.1-24-03. When insured entitled to return of premium. A person insured is entitled to a return of premium, including all policy fees in excess of two dollars, on any one policy, and all other sums of money paid in consideration of the policy of insurance, as follows:

1. To the whole premium, fee, or other sums if no part of the insured's interest in the thing insured is exposed to any of the perils insured against.

2. To the whole of the premium when the contract is voidable on account of the fraud or misrepresentation of the insurer or on account of facts of the existence of which the insured was ignorant without the insured's fault, or when by any default of the insured other than actual fraud, the insurer never incurred any liability under the policy.

3. ~~When~~ Except as provided for in a policy form filed with and approved by the commissioner, when insurance other than life is made for a definite period of time and the insured surrenders the policy, to such proportion of the premium, fee, or other sum as corresponds with the unexpired time upon the amount of the policy remaining after deducting therefrom any claim for loss or damage under the policy which has accrued previously.

Approved March 8, 1983

CHAPTER 343

HOUSE BILL NO. 1321
(Rued)

INSURANCE RATE FILINGS

AN ACT to amend and reenact subsection 2 of section 26-28-04, and subsection 2 of section 26-29-04 of the North Dakota Century Code, or in the alternative to amend and reenact subsection 2 of section 26.1-25-04 of the North Dakota Century Code as created by House Bill No. 1054, as approved by the forty-eighth legislative assembly, relating to insurance rate filings made by insurance rating organizations.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. AMENDMENT. If House Bill No. 1054 does not become effective, subsection 2 of section 26-28-04 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

2. An insurer may satisfy its obligation to make ~~such~~ the filings by becoming a member of, or a subscriber to, a licensed rating organization which makes ~~such~~ the filings, and by authorizing the commissioner to accept such filings on its behalf; provided, that ~~nothing contained in this chapter shall be construed as requiring~~ upon the request of the commissioner the insurer must file information relating to the insurer which supports the filing made by a rating organization prior to the filing becoming effective for the insurer. This chapter does not require any insurer to become a member of or a subscriber to any rating organization.

SECTION 2. AMENDMENT. If House Bill No. 1054 does not become effective, subsection 2 of section 26-29-04 of the North Dakota Century Code is hereby amended and reenacted to read as follows:

2. An insurer may satisfy its obligation to make such filings by becoming a member of, or a subscriber to, a licensed rating organization which makes such filings, and by authorizing the commissioner to accept ~~such~~ the filings on

its behalf; provided, that ~~nothing contained in this chapter shall be construed as requiring~~ upon the request of the commissioner an insurer must file information relating to the insurer which supports the filing made by a rating organization prior to the filing becoming effective for the insurer. This chapter does not require any insurer to become a member of or a subscriber to any rating organization.

SECTION 3. AMENDMENT. Subsection 2 of section 26.1-25-04 of the North Dakota Century Code as created by House Bill No. 1054, as approved by the forty-eighth legislative assembly, is hereby amended and reenacted to read as follows:

2. An insurer may satisfy its obligation to make the filings by becoming a member of, or a subscriber to, a licensed rating organization which makes the filings, and by authorizing the commissioner to accept the filings on its behalf; provided, that ~~this~~ upon the request of the commissioner the insurer must file information relating to the insurer which supports the filing made by a rating organization prior to the filing becoming effective for the insurer. This chapter does not require any insurer to become a member of or a subscriber to any rating organization.

Approved March 4, 1983

CHAPTER 344

SENATE BILL NO. 2224
(Wenstrom)

SENIOR CITIZENS' MOTOR VEHICLE INSURANCE PREMIUMS

AN ACT to provide for a reduction in motor vehicle insurance rates of senior citizens successfully completing a motor vehicle accident prevention course.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF NORTH DAKOTA:

SECTION 1. Motor vehicle insurance rate filings - Premium reduction for accident prevention course completion. All rate filings with the commissioner of insurance for motor vehicle liability and physical damage insurance must provide for an appropriate reduction in premium charges for those persons fifty-five years of age and older for at least a two-year period following their successful completion of a motor vehicle accident prevention course. The course must be approved by the superintendent of the state highway patrol. The course sponsor shall provide each successful participant a certificate which is the basis for the insurance discount.

Approved April 8, 1983