Title 210 – NEBRASKA DEPARTMENT OF INSURANCE

Chapter 60 - UNFAIR PROPERTY AND CASUALTY SETTLEMENT PRACTICES RULE

001. Authority. This rule is adopted under the authority of the Unfair Insurance Claims Settlement Practices Act, pursuant to Neb.Rev.Stat. §§44-1536 through 44-1544.

002. Purpose. This rule sets forth minimum standards for the investigation and disposition of property and casualty claims occurring in the State of Nebraska and arising under insurance policies or certificates which, if violated with such frequency as to indicate a general business practice or committed flagrantly and in conscious disregard, would constitute a violation of the Unfair Insurance Claims Settlement Practices Act or any rule or regulation promulgated thereunder. It is not intended to cover claims involving workers' compensation, fidelity, suretyship or boiler and machinery insurance. Various provisions of this rule are intended to define procedures and practices which constitute unfair insurance claims practices. This rule is not exclusive and other acts, not herein specified, may also be found to constitute such practices.

Nothing herein shall be construed to create nor imply a private cause of action for violation of this rule. This is merely a clarification of original intent and does not indicate any change of position.

This rule shall not apply to claims involving only subrogation rights.

003. Definitions. All definitions contained in the Unfair Insurance Claims Settlement Practices Act are hereby incorporated by reference. As otherwise used in this regulation:

003.01 "Agent" means any individual, corporation, association, partnership or other legal entity authorized to represent an insurer with respect to a claim;

003.02 "Automobile" means a four wheel motor vehicle of the private passenger, station wagon, pickup, panel or delivery type;

003.03 "Claim file" means any retrievable electronic file, microfilm/microfiche file, paper file, or any combination thereof;

003.04 "Claimant" means either a first party claimant, a third party claimant, or both and includes the claimant's designation legal representative or a member of the claimant's immediate family designated by the claimant;

003.05 "Days" means working days;

003.06 "Documentation" includes, but is not limited to, all pertinent communications, transactions, notes, work papers, claim forms, bills and explanation of benefits forms relative to the claim;

003.07 "First party claimant" means an individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by the policy or contract;

003.08 "Investigation" means all activities of an insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy or insurance contract;

003.09 "Notification of claim" means any notification by a claimant, whether in writing or by other means acceptable under the terms of an insurance policy, business custom or statute, to an insurer or its agent which reasonably apprises the insurer of the facts pertinent to a claim;

003.10 "Third party claimant" means any person asserting a claim against any person under a policy or certificate of an insurer; and

003.11 "Written communications" includes all correspondence, regardless of source or type, that is related to the handling of the claim. Written communications shall be effectively communicated when placed in the mail with adequate first class postage.

004. File and record documentation. Each insurer's claim files are subject to examination by the Director of Insurance or by the Director's duly appointed designees. To aid in such examination:

004.01 The insurer shall maintain claim data that is accessible and retrievable for examination. An insurer shall be able to provide the claim number, line of coverage, date of loss and date of payment of the claim, date of denial or date closed without payment. This data must be available for all open and closed files for the current year and the two preceding years.

004.02 Detailed documentation shall be contained in each claim file in order to permit reconstruction of the insurer's activities relative to each claim.

004.03 Each relevant document within the claim file shall be noted as to date received, date processed or date mailed.

004.04 For those insurers that do not maintain hard copy files, claim files must be accessible from Cathode Ray Tube (CRT), Video Display Terminal (VDT)

or micrographics and be capable of duplication to hard copy.

005. Misrepresentation of policy provisions.

005.01 No agent or insurer shall knowingly misrepresent or conceal from first party claimants, any pertinent benefits, coverages, or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim.

005.02 A claim shall not be denied on the basis of failure to exhibit property unless there is documentation of a breach of the policy provisions present in the claim file.

005.03 No insurer shall deny a claim based upon the failure of a first party claimant to give written notice of loss within a specific time limit unless the written notice requirement is a written policy condition, or the first party claimant's failure to give written notice after being requested to do so is so unreasonable as to constitute a breach of the claimant's contractual duty to cooperate with the insurer.

005.04 No insurer shall indicate to a first party claimant on a payment draft, check or in any accompanying letter that said payment is "final" or is "a release" of any claim(s) unless such is the case, or the policy limit has been paid, or there has been a compromise settlement agreed to by the first party claimant and the insurer as to coverage and amount payable under the contract.

005.05 No insurer shall issue checks or drafts in partial settlement of a loss or claim under a specific coverage that contains language purporting to release the insurer or its insured from total liability.

006. Failure to acknowledge pertinent communications.

006.01 Every insurer, upon receiving notification of a claim shall, within fifteen (15) days, acknowledge the receipt of such notice unless payment is made within that period of time. If an acknowledgement is made by means other than writing, an appropriate dated notation of the acknowledgement shall be made in the claim file of the insurer. Notification given to an agent of an insurer shall be notification to the insurer. If notification is given to an agent of an insurer, such agent may acknowledge receipt of such notice. Notice to an agent of an insurer shall not be notice to the insurer if such agent notifies the claimant that the agent is not authorized to receive notices of claim.

006.02 Every insurer, upon receipt of any inquiry from the Director respecting a claim shall furnish the Department, in duplicate, an adequate response to the

inquiry or request additional reasonable time to respond within fifteen (15) days of receipt of such inquiry.

006.03 An appropriate reply shall be made within fifteen (15) days on all other pertinent communications from a claimant which reasonably suggest that a response is expected.

006.04 Every insurer, upon receiving notification of claim, shall provide, within fifteen (15) days, the necessary claim forms, instructions and reasonable assistance so that claimants can comply with the insurer's reasonable requirements and policy conditions. Compliance with this paragraph shall constitute compliance with Subsection 006.01.

007. Standards for the prompt investigation of claims. Every insurer shall, within fifteen (15) days of notification of claim, initiate investigation of any claim presented by a claimant.

008. Standards for prompt, fair and equitable settlements applicable to all insurers.

008.01 Within fifteen (15) days after receipt by the insurer of settlement information or a properly executed proof of loss, the claimant shall be advised of the acceptance or denial of the claim by the insurer. No insurer shall deny a claim on the grounds of a specific policy provision, condition or exclusion unless reference to such provision, condition, or exclusion is included in the denial. The denial must be given to the claimant in writing and the claim file of the insurer shall contain documentation of the denial.

008.02 If the insurer needs more time to determine whether a claim should be accepted or denied, it shall so notify the claimant within fifteen (15) days after receipt of settlement information or the proof of loss, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, thirty (30) days from the initial notification and every thirty (30) days thereafter, send to the claimant a letter setting forth the reasons additional time is needed for investigation. This subsection shall not apply to claims in litigation.

008.03 Where there is a reasonable basis supported by specific information available for review by the Director of Insurance for suspecting that the claimant has fraudulently caused or contributed to the loss, the insurer is relieved from the requirements of subsections 008.01 to 008.02; provided, however, that the claimant shall be advised of the acceptance or denial of the claim by the insurer within a reasonable time for full investigation after receipt by the insurer of settlement information or a properly executed proof of loss.

008.04 In cases where there is no dispute as to coverage as to one or more

portions of the insurance policy and where liability has become reasonably clear, the insurer shall offer to claimants, within fifteen (15) days of receipt of settlement information, amounts within policy limits which are fair and reasonable as shown by the insurer's completed investigation. The insurer shall tender payment within fifteen (15) days of claimant's acceptance. Payment shall be made for any such portion of the insurance policy notwithstanding the existence of disputes as to other portions of the insurance policy coverage where such payment can be made without prejudice to any interested party.

008.05 Insurers shall not fail to settle first party claims on the basis that responsibility for payment should be assumed by others, except as may otherwise be provided by policy provisions.

008.06 Insurers shall not assign a percentage of negligence to a claimant for the purpose of reducing a settlement, when there exists no reasonable evidence upon which the assigned percentage of negligence could be based.

008.07 No insurer shall request or require any insured to submit to a polygraph examination or examination under oath, unless authorized under the applicable insurance contract and not prohibited by state law.

008.08 If the insurer denies a claim or portion thereof, and the claimant objects to such denial, the insurer shall notify the claimant in writing that he or she may have the matter reviewed by the Nebraska Department of Insurance, and the insurer shall provide the claimant with the Department's current address and phone number.

009. Standards for prompt, fair and equitable settlements applicable to losses involving automobiles.

009.01 Where liability and damages are reasonably clear, insurers shall not recommend that third party claimants make claim under their own policies solely to avoid, delay or defer paying claims under such insurer's policy.

009.02 Insurers shall not require a claimant to travel an unreasonable distance either to inspect a replacement automobile, to obtain a repair estimate or to have the automobile repaired at a specific repair shop.

009.03 Insurers shall include the first party claimant's deductible, if any, in subrogation demands, unless requested not to by the first party claimant. Subrogation recoveries shall be shared on a proportionate basis no less than yearly with the first party claimant, unless the first party claimant has otherwise recovered the deductible amount. No deduction for expenses can be made from the deductible recovery unless an outside attorney is retained to

pursue such collection and then the only expenses shared, on a pro rata basis, shall be legal expenses.

009.04 If the insurer designates any repairer owned or affiliated with the insurer, it shall assure that the repairs are performed in a skillful manner and shall comply with this subsection. If non-total losses are settled on the basis of a written estimate prepared by or for the insurer, the insurer shall supply the claimant a copy of the estimate upon which the settlement is based. The estimate prepared by or for the insurer shall be reasonable, in accordance with applicable policy provisions, and of an amount which will allow for repairs to be made in a skillful manner. If the claimant subsequently claims, based upon a written estimate which was obtained, that necessary repairs will exceed the written estimate prepared by or for the insurer, the insurer may (1) pay the difference between the written estimate and a higher estimate obtained by the claimant, or (2) promptly provide the claimant with the name of at least one quality repair shop that will make the repairs for the amount of the written estimate, or (3) contact the repair shop of the claimant's choice for repair, to negotiate the amount of the written estimate for repair. The insurer shall maintain documentation of all such communications.

009.05 When the amount claimed is reduced because of betterment or depreciation, all information for such reduction shall be contained in the claim file. Such deductions shall be measurable, discernable, itemized and specified as to dollar amount and shall be appropriate for the amount of deductions.

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

009.07 Storage and Towing. The insurer shall provide reasonable notice to the claimant prior to termination of payment for automobile storage charges and shall document same as is required by section 004. Such insurer shall provide reasonable time for removal of the vehicle from storage prior to the termination of payment. Unless the insurer has provided the first party claimant with the name of a specific towing company prior to the use of another towing company, the insurer shall pay any and all reasonable towing charges irrespective of the towing company used.

010. Standards for prompt, fair and equitable settlements applicable to fire and extended coverage type policies.

010.01 Replacement Cost Coverage: When the insurance policy authorizes for the adjustment and settlement of losses based on replacement cost, the

following shall apply:

010.01(A) When a loss requires repair or replacement of an item or part, any consequential physical damage incurred in making such repair or replacement not otherwise excluded by the policy, shall be included in the loss. Repair or replacement of consequential physical damage which requires the use of materials which are better or superior to the damaged materials shall not be considered betterment unless the use of such materials is at the request of the insured.

010.01(B) When a loss requires replacement of items and the replacement items do not reasonably match in quality, color or size, the insurer shall replace all items in the area so as to conform to a reasonably uniform appearance. This applies to both interior and exterior losses. The insured shall not bear cost over any applicable deductible.

010.02 Actual Cash Value Coverage: When the insurance policy provides for the adjustment and settlement of losses based on actual cash value, the following shall apply:

010.02(A) The insurer shall determine actual cash value, and shall provide a copy of the worksheet(s) detailing any and all deductions.

010.02(B) In cases in which the insured's interest is limited because the property has nominal or no market value, the insurer shall provide a written explanation of the basis for limiting the amount payable.

011. Standards for overpayment recovery applicable to all insurers.

011.01 No insurer shall withhold any portion of any benefit payable or request any refund, on the basis that the sum withheld or the refund requested is an adjustment or correction of an overpayment made on a prior claim arising under the same policy unless:

011.01(A) The insurer has within its files clear, documented evidence of an overpayment and written authorization from the claimant permitting such withholding procedure, or

011.01(B) The insurer has within its files clear, documented

evidence that:

011.01(B)(1) The overpayment was clearly erroneous under the provisions of the policy. If the overpayment is the subject of a reasonable dispute as to facts, this procedure may not be used; and

011.01(B)(2) The error which resulted in the overpayment is not a mistake of law; and

011.01(B)(3) The insurer has notified the claimant within six (6) months of the date of the error, except that in instances of error prompted by representations or nondisclosures of claimants, the insurer notifies the claimant within fifteen (15) days after the date that clear, documented evidence of discovery of such error is included in its file; and

011.01(B)(4) Such notice states clearly the nature of the error, the amount of the overpayment, and the three year limitation as provided in subsection 011.01(C).

011.01(C) An insurer may use the procedure set forth in subsection 011.01(B) provided that the claim used to adjust the first overpayment is made no later than three years after the date of the error.

011.02 For the purpose of Section 011, the date of the error shall be the day on which the draft for benefits is issued.

012. Severability. If any section or portion of this Rule or the applicability thereof to any person or circumstance is held invalid by a court, the remainder of the rule or the

applicability of such provision to other persons or circumstances shall not be affected thereby.

013. Effective date. This rule shall become operative on September 1, 1992.