TITLE 26 - INSURANCE CODE

CHAPTER 1 - SCOPE OF CODE

26-1-101. Short title.

This act constitutes the Wyoming Insurance Code.

26-1-102. Definitions.

(a) As used in this act:

(i) "Adjuster" means any individual who either investigates and negotiates settlements relative to insurance claims or applies the factual circumstances of an insurance claim to the insurance policy provisions, or both, arising under property and casualty insurance contracts. An attorney-at-law who is licensed to practice law in this state, or a licensed agent or broker who adjusts or assists in adjustment of losses arising under policies issued through that broker or by the insurer represented by that agent, is not an adjuster for the purposes of chapter 9 of this code;

(ii) "Agent" means any individual, firm or corporation appointed by an insurer to solicit applications for insurance or annuities or to negotiate insurance or annuities on its behalf;

(iii) "Alien" insurer means an insurer formed under the laws of any country other than the United States of America or any of its states;

(iv) "Annuity" means a contract under which obligations are assumed with respect to periodic payments where the making or continuance of all or some of the payments, or the amount of the payments, is dependent upon the continuance of human life, and a contract which includes extra benefits of the kinds set forth in W.S. 26-5-102 and 26-5-103 is an annuity if the extra benefits constitute a subsidiary or incidental part of the entire contract;

(v) "Authorized" insurer means an insurer authorized by a subsisting certificate of authority issued by the commissioner to transact insurance in this state;

(vi) "Broker", except as used in chapter 11 of this code, means a resident individual, firm or corporation organized

under the laws of the state of Wyoming who, not being an agent of the insurer, as an independent contractor and on behalf of the insured, for compensation or fee solicits, negotiates or procures insurance or the renewal or continuance thereof for insureds or prospective insureds, other than himself;

(vii) "Charter" means articles of incorporation, agreement or association, charter granted by legislative act, or other basic constituent document of a corporation or the power of attorney of the attorney-in-fact of a reciprocal insurer;

(viii) "Commissioner" means the insurance commissioner of this state;

(ix) "Department" means the department of insurance of this state, unless the context otherwise requires;

(x) "Domestic" insurer means an insurer formed under the laws of Wyoming;

(xi) "Domicile" of an insurer means:

(A) As to Canadian insurers, Canada and the province in which the insurer's head office is located;

(B) As to other alien insurers authorized to transact insurance in one (1) or more states as provided in W.S. 26-3-130;

(C) As to alien insurers not authorized to transact insurance in one (1) or more states, the country under the laws of which the insurer was formed;

(D) As to all other insurers, the state under the laws of which the insurer was formed.

(xii) "Foreign insurer" means an insurer formed under the laws of any jurisdiction other than this state and includes an "alien" insurer unless otherwise distinguished by the context;

(xiii) "General lines agent" means an agent who transacts any of the following kinds of insurance:

(A) Property insurance;

(B) Casualty insurance;

(C) Surety insurance;

(D) Marine and transportation insurance;

(E) Disability insurance, if transacted for an insurer also represented by the same agent as to property or casualty insurance.

(xiv) "Industrial life insurance" means life insurance written under policies of face amount of one thousand dollars ($1,000.00) or less bearing the words "industrial policy" imprinted on the face of the policy and under which premiums are payable monthly or more often;

(xv) "Insurance" means a contract in which one undertakes to indemnify another against loss, damage or liability arising from determinable hazards or fortuitous occurrences or to pay or allow a specified amount or determinable benefit in connection with ascertainable risk contingencies;

(xvi) Except as otherwise provided in W.S. 26-22-501 through 26-22-503, "insurer" means any person engaged as indemnitor, surety or contractor in the business of entering into contracts of insurance or of annuity;

(xvii) "Life agent" means an agent who transacts life insurance or annuity business and includes also the transaction of disability insurance on behalf of an insurer for whom the agent is also licensed as to life insurance;

(xviii) "Managing general agent" means a person, firm, association or corporation meeting the definition of managing general agent under W.S. 26-46-101;

(xix) "Mutual insurer" means an incorporated insurer without capital stock and the governing body of which is elected by its policyholders, except certain foreign insurers which the commissioner finds to be organized on the mutual plan under the laws of their state or province of domicile, but having temporary share capital or providing for election of the insurer's governing body on a reasonable basis by members or by policyholders and others are not excluded as mutual insurers;

(xx) Except as used in chapter 31 of this code, "person" means an individual, insurer, company, association,

organization, Lloyd's insurer, society, reciprocal insurer or interinsurance exchange, partnership, syndicate, business trust, corporation, agent, general agent, broker, adjuster and any legal entity;

(xxi) "Policy" means the written contract of or written agreement for or effecting insurance, by whatever name called, and includes all clauses, riders, endorsements and papers which are a part thereof;

(xxii) "Premium" means the consideration for insurance, by whatever name called, and any assessment, membership, policy, survey, inspection, service or similar fee or other charge in consideration for an insurance contract is part of the premium;

(xxiii) "Reciprocal insurance" means insurance from an interexchange among persons, known as subscribers, of reciprocal agreements of indemnity, the interexchange being carried out through an attorney-in-fact common to all persons involved;

(xxiv) "Reciprocal insurer" means an unincorporated aggregation of subscribers operating individually and collectively through an attorney-in-fact to provide reciprocal insurance among themselves;

(xxv) Repealed By Laws 2011, Ch. 60, § 3.

(xxvi) Repealed by Laws 2001, Ch. 201, § 5.

(xxvii) "State" means any state, district, territory, commonwealth or possession of the United States of America and the Panama Canal Zone if used in a context signifying a jurisdiction other than the state of Wyoming;

(xxviii) "Stock insurer" means an incorporated insurer with its capital divided into shares and owned by its stockholders;

(xxix) "Surplus" in any determination or statement of an insurer's financial condition means the excess of the insurer's assets over its liabilities as ascertained in accordance with chapter 6 of this code;

(xxx) "Transact" with respect to a business of insurance means:

(A) Solicitation or inducement;

(B) Negotiations;

(C) Carrying out of a contract of insurance;

(D) Transaction of matters subsequent to the carrying out and arising out of a contract of insurance; or

(E) Any other aspects of insurance operations to which this code applies.

(xxxi) "Unauthorized" insurer means an insurer not authorized as provided in paragraph (a)(v) of this section;

(xxxii) "This act" or "this code" means title 26 of the Wyoming statutes;

(xxxiii) "Private health benefit plan" means any hospital or medical policy or certificate, major medical expense insurance, hospital or medical service plan contract or health maintenance organization subscriber contract. "Private health benefit plan" does not include accident only, credit, dental, vision, Medicare supplement, long-term care or disability income insurance, policies or certificates providing coverage for a specified disease or hospital confinement indemnity or limited benefit health insurance, coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, automobile medical payment insurance or any hospital or medical policy, major medical expense insurance, hospital or medical service plan or contract which by contract or product design is intended to provide coverage for six (6) months or less. Notwithstanding other provisions of this section, the Medicaid program shall continue to obtain reimbursement recovery from all types of insurance included in this section prior to July 2, 2011;

(xxxiv) "Public health benefit plan" means medicare, medicaid or other health benefit programs or coverages operated or maintained by any governmental entity;

(xxxv) "Insurance producer" means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance, including, but not limited to, agents and brokers;

(xxxvi) "Fair value", "fair market value" or "market value" mean fair value as determined pursuant to the most recent National Association of Insurance Commissioners' accounting practices and procedures manual;

(xxxvii) "Consumer reporting agency" means any person who does any of the following:

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

(B) Obtains information primarily from sources other than insurers;

(C) Furnishes consumer reports to other persons.

(xxxviii) "Insurance support organization" means:

(A) Any person who regularly engages, in whole or in part, in the practice of assembling or collecting information about natural persons for the primary purpose of providing the information to an insurance institution or insurance producer for insurance transactions, including the furnishing of consumer reports or investigative consumer reports to an insurer or insurance producer for use in connection with an insurance transaction or the collection of personal information from insurers, insurance producers or other insurance support organizations for the purpose of detecting or preventing fraud, material misrepresentation or material nondisclosure in connection with insurance underwriting or insurance claim activity;

(B) Notwithstanding subparagraph (A) of this paragraph the following persons are not considered insurance support organizations for purposes of this code:

(I) Insurance producers;

(II) Government institutions;

(III) Insurers;

(IV) Medical care institutions;

(V) Medical professionals.

(xxxix) "Insurance transaction" means:

(A) For the purposes of paragraph (xxxviii)of this subsection, any transaction involving insurance primarily for personal, family or household needs rather than business or professional needs and which entails the determination of an individual's eligibility for an insurance coverage, benefit or payment or the servicing of an insurance application, policy, contract or certificate;

(B) For all other purposes except as provided in subparagraph (A) of this paragraph, any transaction involving insurance, including any act specified in paragraph (xxx) of this subsection.

(xl) "Investigative consumer report" means a consumer report or portion of a consumer report in which information about a natural person's character, general reputation, personal characteristics or mode of living is obtained through personal interviews with the person's neighbors, friends, associates, acquaintances or others who may have knowledge concerning those items of information;

(xli) "NAIC" means the National Association of Insurance Commissioners;

(xlii) A natural person who engages in or conducts the "business of insurance" means a person has duties that require licensure under this code or that are a major part of a person's duties and require specialized knowledge of insurance, which knowledge has been acquired through training and experience and is sufficient that close supervision from a person licensed under this code is not needed. A person is not engaged in the business of insurance who performs tasks often found in business offices not engaged in insurance and who requires close supervision from a person licensed under this code to engage in tasks requiring specialized insurance knowledge. A person in training who performs duties requiring specialized knowledge of insurance is not engaged in the business of insurance if that person is under close supervision from a person licensed under this code;

(xliii) "Multiple employer welfare arrangement" means an employee welfare benefit plan, as defined in 29 U.S.C. § 1002, or any other arrangement which is established to provide hospital, medical or surgical benefits in the event of sickness, accident, disability or death to the employees of two (2) or

more employers, which may include self employed individuals, meeting a commonality of interest test, or to the beneficiaries of these persons. This term shall include a bona fide group or association of employers authorized to establish an employee welfare benefit plan under federal law.

(b) As used in W.S. 26-2-116 through 26-2-124:

(i) "Examiner" means any individual or firm authorized by the commissioner to conduct an examination under W.S. 26-2-116 through 26-2-124;

(ii) "Person" means as defined in W.S. 26-1-102(a)(xx) and includes all affiliates of the entities referred to in that definition and air ambulance membership organizations as identified in chapter 43, article 3 of this code.

26-1-103. Compliance with insurance code required.

No person shall transact a business of insurance in Wyoming, or relative to a subject of insurance resident, located or to be performed in Wyoming, without complying with the applicable provisions of this code.

26-1-104. Applicability of provisions.

(a) This code does not apply to:

(i) Repealed by Laws 2018, ch. 21, § 2.

(ii) Fraternal benefit societies as identified in chapter 29 of this code, except as stated in that chapter;

(iii) Health maintenance organizations as identified in chapter 34 of this code, except as otherwise specifically provided in that chapter;

(iv) Transactions in mechanical breakdown insurance as identified in chapter 37 of this code, except as otherwise provided in that chapter;

(v) Health care sharing ministries. As used in this section, "health care sharing ministry" means a faith-based nonprofit organization that is tax exempt under the Internal Revenue Code and which:

(A) Coordinates financial sharing for medical expenses among willing participants in accordance with criteria established by the health care sharing ministry;

(B) Has annual audits performed by an independent certified public accountant that are available upon request; and

(C) Includes a written disclaimer on or accompanying all applications and guideline materials distributed by or on behalf of the organization that reads in substance: "Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an insurance policy. Any assistance with your medical bills is completely voluntary. No other participant is compelled by law or otherwise to contribute toward your medical bills. Participation in the organization or a subscription to any of its documents shall not be considered to be health insurance and is not subject to the regulatory requirements or consumer protections of the Wyoming insurance code. You are personally responsible for payment of your medical bills regardless of any financial sharing you may receive from the organization for medical expenses. You are also responsible for payment of your medical bills if the organization ceases to exist or ceases to facilitate the sharing of medical expenses."

(vi) A direct primary care agreement. A direct primary care agreement means a written agreement that:

(A) Is between a patient or their legal representative and a health care provider;

(B) Allows either party to terminate the agreement in writing, without penalty or payment of a termination fee, at any time or after notice as specified in the agreement which notice shall not exceed sixty (60) days;

(C) Describes the health care services to be provided in exchange for payment of a periodic fee;

(D) Specifies the periodic fee required and any additional fees that may be charged;

(E) May allow the periodic fee and any additional fees to be paid by a third party;

(F) Prohibits the provider from charging or receiving additional compensation for health care services included in the periodic fee; and

(G) Conspicuously and prominently states that the agreement is not health insurance and does not meet any individual health insurance mandate that may be required by federal law.

(vii) Air ambulance membership organizations as identified in chapter 43, article 3 of this code, except as otherwise specifically provided in this title;

(viii) Theft protection program warranties, except as referred to in chapter 49 of this code. Theft protection program warranties shall not be considered insurance.

26-1-105. Provisions relating to particular insurance to prevail over general provisions.

Provisions of this code relative to a particular kind of insurance or type of insurer or particular matter prevail over provisions relating to insurance in general or insurers in general or to the particular matter in general.

26-1-106. Captions or headings not to limit scope of provisions.

The scope and meaning of any provision are not limited or otherwise affected by the caption or heading of any chapter, section or provision.

26-1-107. General criminal and civil penalties.

(a) Each violation of this code for which a greater penalty is not provided by another provision of this code or by other applicable laws of this state, in addition to any applicable prescribed denial, suspension or revocation of certificate of authority or license, is a misdemeanor punishable upon conviction by a fine of not more than one thousand dollars ($1,000.00), or by imprisonment in the county jail for not more than six (6) months, or both. Each violation is a separate offense.

(b) Any person who violates, or who instructs his agent or adjuster to violate, any provision of this code, any lawful rule or final order of the commissioner or any final judgment or

decree made by any court, upon the commissioner's application, shall pay a civil penalty in an amount the commissioner determines of not more than five thousand dollars ($5,000.00) for each offense, or fifty thousand dollars ($50,000.00) in the aggregate for all offenses within any one (1) year period. In the case of individual agents or adjusters, the civil penalty shall be not more than one thousand dollars ($1,000.00) for each offense or ten thousand dollars ($10,000.00) in the aggregate for all offenses within any one (1) year period. The penalty shall be collected from the violator and paid by the commissioner, or the appropriate court, to the state treasurer and credited as provided in W.S. 8-1-109.

(c) Before the commissioner imposes a civil penalty, he shall notify the person, agent or adjuster accused of a violation, in writing, stating specifically the nature of the alleged violation and fixing a time and place, at least ten (10) days from the date of the notice, when a hearing of the matter shall be held. After hearing or upon failure of the accused to appear at the hearing, the commissioner shall determine the amount of the civil penalty to be imposed in accordance with the limitations expressed in subsection (b) of this section. Each violation is a separate offense.

(d) A civil penalty may be recovered in an action brought thereon in the name of the state of Wyoming in any court of appropriate jurisdiction, and the court may review the penalty as to both liability and reasonableness of amount.

(e) The provisions of this section are in addition to and not instead of any other enforcement provisions contained in this code.

26-1-108. Jurisdiction of insurance department.

(a) Notwithstanding any other provision of law, and except as provided in this section, any person or other entity which provides insurance coverage in this state for medical, surgical, chiropractic, physical therapy, speech pathology, audiology, professional mental health, dental, hospital or optometric expenses, whether the coverage is by direct payment, reimbursement, or otherwise, shall be subject to the jurisdiction of the state insurance department, unless the person or other entity shows that while providing the services it is subject to the exclusive jurisdiction of another agency of this state or the federal government.

(b) A person or entity may show that it is subject to the exclusive jurisdiction of another agency of this state or the federal government, by providing to the insurance commissioner the appropriate certificate, license or other document issued by the other governmental agency which permits or qualifies it to provide those services.

(c) Any person or entity which is unable to show under subsection (b) of this section that it is subject to the exclusive jurisdiction of another agency of this state or the federal government, shall submit to an examination by the insurance commissioner to determine the organization and solvency of the person or the entity, and to determine whether or not the person or entity complies with the applicable provisions of this code.

(d) Any person or entity unable to show that it is subject to the exclusive jurisdiction of another agency of this state or the federal government, shall be subject to all appropriate provisions of this code regarding the conduct of its business. If a person or entity is subject to the exclusive jurisdiction of another agency of this state or the federal government, this fact shall be disclosed on all policy forms.

(e) Any production agency or administrator which advertises, sells, transacts or administers the coverage in this state described in subsection (a) of this section and which is required to submit to an examination by the insurance commissioner under subsection (c) of this section, shall, if the 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 every purchaser, prospective purchaser and covered person of such lack of insurance or other coverage. Any administrator which advertises or administers the coverage in this state described in subsection (a) of this section and which is required to submit to an examination by the insurance commissioner under subsection (c) of this section, shall advise any production agency of the elements of the coverage, including the amount of "stop-loss" insurance in effect.

CHAPTER 2 - THE INSURANCE COMMISSIONER

ARTICLE 1 - COMMISSIONER

26-2-101. Department of insurance established.

There is established the department of insurance.

26-2-102. Insurance commissioner; appointment; vacancy; removal from office; other requirements.

(a) The chief officer of the department is the "insurance commissioner".

(b) The commissioner shall be appointed by the governor.

(c) If for any cause a vacancy occurs in the office of commissioner, the governor shall fill the vacancy in accordance with W.S. 28-12-101.

(d) The governor may remove a commissioner as provided in W.S. 9-1-202.

(e) Effective July 1, 1979, appointments and terms shall be in accordance with W.S. 28-12-101 through 28-12-103.

26-2-103. Insurance commissioner; eligibility for appointment.

No individual is eligible for appointment to or shall hold the office of commissioner unless he is a qualified elector of this state and free of conflicting interests as specified in W.S. 26-2-107.

26-2-104. Insurance commissioner; official seal.

(a) The commissioner shall have an official seal in the form and design in use and on file in the office of secretary of state.

(b) The commissioner shall issue under his official seal all his certificates, other than licenses of agents, brokers, adjusters and other insurance representatives.

26-2-105. Insurance commissioner; salary.

The commissioner shall receive a salary as provided under W.S. 9-2-3207.

26-2-106. Deputy commissioner, examiners, clerks, assistants and consultants.

(a) The commissioner, with the governor's approval, may appoint a deputy commissioner and may revoke the appointment at his pleasure.

(b) The commissioner may appoint examiners, clerks and other necessary assistants as the proper conduct of his office requires, and may revoke the appointments at his pleasure. In the appointment of examiners the commissioner shall consider standards of qualification the National Association of Insurance Commissioners recommends.

(c) Salary for personnel in subsections (a) and (b) of this section shall be as provided under W.S. 9-2-3207.

(d) The commissioner may contract for independent or consulting actuarial, rating or other technical services, on a fee basis, without giving the individual status as a state employee.

26-2-107. Conflict of interest prohibited; additional compensation prohibited.

(a) The commissioner or his deputy, or any examiner, assistant or employee of the department shall not:

(i) Be connected with the management of or be financially interested in any insurer, insurance agency or insurance transaction except as a policyholder or claimant under a policy;

(ii) Engage in any other business or occupation interfering or inconsistent with department duties, except that as to those matters in which a conflict of interest does not exist on the part of any individual, the commissioner may employ or retain insurance actuaries, accountants or other technicians who are independently practicing their professions even though similarly employed or retained by insurers or others; or

(iii) Be given or receive any fee, compensation, loan, gift or other thing of value in addition to the compensation and expense allowance provided by law.

26-2-108. Commissioner; delegation of authority.

(a) The commissioner may delegate to his deputy or any department employee the exercise or discharge in the commissioner's name of any power, duty, or function vested in or

imposed upon the commissioner under this code, other than the supervision of department operations.

(b) The official act of any individual acting in the commissioner's name and by his authority is an official act of the commissioner. The commissioner is responsible for all such acts.

26-2-109. Commissioner; powers and duties generally.

(a) The commissioner shall:

(i) Personally supervise the department operations;

(ii) Examine and inquire into violations of this code;

(iii) Enforce this code with impartiality;

(iv) Execute the duties imposed upon him by this code;

(v) Have the powers and authority expressly conferred upon him by or reasonably implied from this code;

(vi) Immediately pay to the state treasurer for deposit in the general fund, unless otherwise specifically provided, any monies paid to him under this code;

(vii) Have any additional powers and duties as may be provided by other laws of this state.

(b) The commissioner may conduct examinations and investigations of insurance matters, in addition to examinations and investigations expressly authorized, as he deems proper, upon reasonable and probable cause, to determine whether any person has violated any provisions of this code or to secure information useful in the lawful administration of any provision of this code. The cost of any additional examinations and investigations shall be borne by the state.

(c) The commissioner, with the governor's approval, may enter into interstate compacts with other states in the region to provide for a uniform climate for insurance coverage in the compacting states. The compacts may include:

(i) Interstate compacts to negotiate uniform rating structures in the compacting states;

(ii) Interstate compacts to negotiate the use of regional ratings or trendings rather than national ratings or trendings; or

(iii) Interstate compacts to provide for the operation of mutual companies to provide insurance for risks that are critical to the health, safety or welfare of the compacting states.

(d) Repealed by Laws 2017, ch. 9, § 3.

(e) The commissioner may request a waiver from the NAIC's financial regulation standards and accreditation program requirements when the commissioner deems the waiver to be in the interest of the state. The commissioner shall report in writing any waiver request to the joint corporations, elections and political subdivisions interim committee within thirty (30) days of the request.

26-2-110. Rules and regulations.

(a) Subject to the requirements of the Wyoming Administrative Procedure Act , the commissioner may make reasonable rules and regulations necessary to carry out any provision of this code. No rule or regulation shall extend, modify or conflict with any law of this state or the reasonable implications thereof.

(b) Any interested person may petition the commissioner requesting the promulgation, amendment or repeal of any rule or regulation, under the applicable procedures of the Wyoming Administrative Procedure Act.

(c) In addition to any other penalty under this code, willful violation of any provision of this code or any rule or regulation promulgated pursuant thereto subjects the violator to suspension or revocation of a certificate of authority or license as may be applicable. No penalty applies to any act done or omitted in good faith in conformity with the rule or regulation, notwithstanding that after the act or omission the rule or regulation may be amended or rescinded or determined by judicial or other authority to be invalid.

(d) In addition to all other rulemaking authority granted to the commissioner, the commissioner may promulgate necessary and appropriate rules to satisfy NAIC accreditation requirements, provided that:

(i) The commissioner has determined promulgation of the rules is in the interest of the state and the rules are otherwise appropriate;

(ii) The rules shall not be in effect for longer than three (3) years; and

(iii) The commissioner has requested a waiver, if determined appropriate, to the applicable NAIC accreditation requirement pursuant to W.S. 26-2-109(e).

(e) The commissioner may promulgate rules to identify procedures for conducting examinations of the Wyoming state employees' and officials' group insurance program in accordance with W.S. 9-3-205(c).

26-2-111. Orders and notices of commissioner; contents; delivery.

(a) Orders and notices of the commissioner are effective only when in writing signed by him or by his authority.

(b) Except as otherwise expressly provided by law as to particular orders, any order of the commissioner shall concisely state:

(i) Its effective date;

(ii) Its intent or purpose;

(iii) The grounds on which based;

(iv) The provisions of this code pursuant to which action is so taken or proposed to be taken, but failure to designate a particular provision does not deprive the commissioner of the right to rely on that provision.

(c) Except as may be provided as to particular procedures, an order or notice may be given by delivery to the person to be ordered or notified or by mailing it, postage prepaid, addressed to him at his principal place of business or residence as last

of record in the department. The order or notice is deemed to have been given when so mailed.

26-2-112. Enforcement of code and orders; injunctions; penalty for violation of orders.

(a) The commissioner, upon the advice of and through the attorney general, may invoke the aid of the courts through injunction or other proper process to enforce any proper order he makes or action he takes.

(b) If the commissioner has reason to believe that any person has violated any provision of this code, or any provision of other law applicable to insurance operations, for which criminal prosecution is provided and would be in order, he shall give the information relative thereto to the attorney general or to the district attorney for the county having jurisdiction of the violation. The attorney general or district attorney shall promptly institute any action or proceedings against the person as in his opinion the information requires or justifies.

(c) In addition to any other applicable penalty, any person who violates a lawful order of the commissioner, upon proof thereof to the court's satisfaction, shall pay to this state a sum not to exceed one thousand dollars ($1,000.00), or if the violation is found to be willful, a sum not to exceed two thousand dollars ($2,000.00). Any penalty may be recovered in a civil action against the violator.

26-2-113. Records and other papers; generally.

(a) The commissioner shall:

(i) File in the department and safely keep all statements, reports, filings and papers required by law;

(ii) Preserve in the department in permanent form records of his proceedings, hearings, investigations and examinations;

(iii) Keep a suitable record of all insurer certificates of authority and of all licenses issued under this code together with all applicable suspensions and revocations and of the causes thereof.

(b) The records and filings in the department are open to public inspection, except as otherwise provided by this code.

(c) The commissioner may destroy unneeded or obsolete records and filings in the department in accordance with general provisions and procedures applicable to administrative agencies of this state.

(d) In order to assist in the performance of his duties under this code, the commissioner may:

(i) Share documents, materials or other information, including confidential and privileged documents, materials or information, with other state, federal and international regulatory agencies, with the National Association of Insurance Commissioners, its affiliates or subsidiaries, and with state, federal and international law enforcement authorities, including members of any supervisory college described in W.S. 26-44-118, provided the recipient agrees in writing to maintain the confidentiality and privileged status of any document, material or other information and has verified in writing the legal authority to maintain confidentiality;

(ii) Receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the National Association of Insurance Commissioners, its affiliates or subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(iii) Enter into agreements governing sharing and use of information consistent with this subsection.

26-2-114. Records and other papers; reproductions and certified copies.

(a) Reproductions of records or documents on file in the department, when certified by the commissioner, shall be received in evidence in all proceedings and courts and have the same effect and force as the originals.

(b) Upon request of any person and payment of the applicable fee, the commissioner shall furnish a certified copy of any record or document in the department which is then subject to public inspection.

26-2-115. Report to governor.

(a) The commissioner, as required by W.S. 9-2-1014, shall report to the governor showing:

(i) A list of authorized insurers transacting insurance in this state, with any tabular summary of their financial statements as he deems appropriate;

(ii) Names of all insurers whose business was closed during the preceding reporting period, the cause thereof and the amount of assets and liabilities as ascertainable;

(iii) Names of insurers against which delinquency or similar proceedings were instituted, and a concise statement of the facts with respect to each proceeding and the status thereof;

(iv) The department receipts and expenses for the preceding reporting period;

(v) His recommendations as to amendments or supplementation of laws affecting insurance or the department; and

(vi) Any other matters he deems proper or of benefit to the public in regard to the insurance business in this state.

26-2-116. Examination of insurers.

(a) For the purpose of determining financial condition, ability to fulfill and manner of fulfillment of its obligations, the nature of its operations and compliance with law, the commissioner or any of his examiners may examine any insurer as often as he, in his sole discretion, deems advisable. He shall examine each insurer licensed in this state not less frequently than every five (5) years. Examination of a reciprocal insurer may include examination of its attorney-in-fact as to its transactions relating to the insurer. Examination of an alien insurer may be limited to its insurance transactions and affairs in the United States, except as the commissioner otherwise requires. In scheduling and determining the nature, scope and frequency of the examinations the commissioner shall consider such matters as the results of financial statement analyses and ratios, changes in management or ownership, actuarial opinions, reports of independent certified public accountants and other

criteria as set forth in the Examiners' Handbook adopted by the National Association of Insurance Commissioners and in effect when the commissioner exercises discretion under this section.

(b) The commissioner shall in like manner examine each insurer applying for an initial certificate of authority to transact insurance in this state.

(c) Repealed by Laws 1992, ch. 59, § 3.

(d) In lieu of making his own examination of any foreign or alien insurer licensed in this state, the commissioner may accept an examination report on the company as prepared by the insurance department for the company's state of domicile or port of entry state until January 1, 1994. Thereafter, such reports may only be accepted if:

(i) The insurance department preparing the report was, at the time of the examination, accredited under the National Association of Insurance Commissioners' financial regulation standards and accreditation program; or

(ii) The examination is performed under the supervision of an accredited insurance department or with the participation of one (1) or more examiners who are employed by an accredited insurance department and who, after the review of the examination work papers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by their insurance department.

26-2-117. Examination of other than insurers.

(a) For the purpose of ascertaining compliance with law, or relationships and transactions between any person and any insurer or proposed insurer, the commissioner, as often as he deems advisable, may examine the accounts, records, documents and transactions pertaining to or affecting insurance affairs or proposed insurance affairs of any person:

(i) Who is or holds himself out to be an insurance agent, broker, general agent, adjuster or insurer representative;

(ii) Having a contract under which he enjoys in fact the exclusive or dominant right to manage or control an insurer;

(iii) Holding the shares of voting stock or the policyholder proxies of a domestic insurer, for the purpose of controlling the management thereof, as voting trustee or otherwise;

(iv) Engaged in or in any way involved or proposing to be involved in this state in the promotion, formation or financing of an insurer or insurance holding corporation, or corporation or other group to finance an insurer or the production of its business.

26-2-118. Examinations; generally.

(a) Each examination shall be expeditious, fair and impartial. Upon determining that an examination should be conducted the commissioner or his designee shall issue an examination warrant appointing one (1) or more examiners to perform the examination and instructing them as to the scope of the examination. In conducting the examination the examiner shall observe those guidelines and procedures set forth in the Examiners' Handbook adopted by the National Association of Insurance Commissioners. The commissioner may also employ other guidelines or procedures as the commissioner deems appropriate. No examiner may be appointed by the commissioner if the examiner, either directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in any person subject to examination under this act. This subsection shall not be construed to automatically preclude an examiner from being:

(i) A policyholder or claimant under an insurance policy;

(ii) A grantor of a mortgage or similar instrument on the examiner's residence to a regulated entity if done under customary terms and in the ordinary course of business;

(iii) An investment owner in shares of regulated diversified investment companies; or

(iv) A settlor or beneficiary of a "blind trust" into which any otherwise impermissible holdings have been placed.

(b) For purposes of completing an examination of any insurer under this act, the commissioner may examine or investigate any person, or the business of any person, if in the sole discretion of the commissioner, the examination or

investigation is necessary or material to the examination of the insurer.

(c) Any insurer or other person being examined and any officers, directors, employees, agents or other representatives thereof shall make freely available to the commissioner or his examiners all accounts, computer and other records, documents, files, information, assets and matters in his possession or control relating to the subject of the examination and shall facilitate the examination. The officers, directors, employees, agents and other representatives of the insurer or person shall facilitate the examination and aid in the examination so far as it is in their power to do so. The refusal of any insurer, by its officers, directors, employees, agents or other representatives to submit to examination or to comply with any reasonable written request of the examiners shall be grounds for suspension or refusal of, or nonrenewal of any license or authority held by the insurer to engage in an insurance or other business subject to the commissioner's jurisdiction. Any such proceedings for suspension, revocation or refusal of any license or authority shall be conducted pursuant to W.S. 26-2-125 through 26-2-130.

(d) Repealed by Laws 1993, ch. 134, § 2.

(e) Neither the commissioner nor any examiner shall remove any record, account, document, file or other property of the person being examined from the offices or place of that person except with that person's written consent in advance of the removal or pursuant to a court order. This provision does not affect the making and removal of copies or abstracts of any record, account, document or file.

(f) When making an examination under W.S. 26-2-116 through 26-2-124, the commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants or other professionals and specialists as examiners, the reasonable and appropriate cost shall be borne by the insurer which is the subject of the examination. Notwithstanding the conflict of interest provisions of subsection (a) of this section, the commissioner may retain from time to time, on an individual basis, qualified actuaries, certified public accountants or other similar individuals who are independently practicing their professions, even though the persons may from time to time be similarly employed or retained by persons subject to examination under this act.

(g) Nothing contained in W.S. 26-2-116 through 26-2-124 shall be construed to limit the commissioner's authority to terminate or suspend any examination in order to pursue other legal or regulatory action pursuant to the insurance laws of this state. Findings of fact and conclusions made pursuant to any examination shall be prima facie evidence in any legal or regulatory action.

(h) Nothing contained in W.S. 26-2-116 through 26-2-124 shall be construed to limit the commissioner's authority to use and, if appropriate, to make public any final or preliminary examination report, any examiner or company work papers or other documents, or any other information discovered or developed during the course of any examination in the furtherance of any legal or regulatory action which the commissioner may, in his sole discretion, deem appropriate.

26-2-119. Repealed by Laws 1993, ch. 134, § 2.

26-2-120. Examinations; deceit and obstruction during examination prohibited.

No person shall make or authorize any false certificate, entry, memorandum or writing in or relative to the books, records, files, documents and affairs of the person being examined with the intent to deceive the commissioner or examiner, or otherwise willfully obstruct the examination.

26-2-121. Examinations; report; contents.

(a) No later than sixty (60) days following completion of the examination the examiner in charge shall make a verified, full and true written report of any examination he makes and shall therein certify under oath the report and his findings. Investigations initiated by the commissioner or his examiners and assistants for the purpose of ascertaining whether an insurer, agent or adjuster has violated any provision of the insurance code are not examinations within the provisions of this section.

(b) The report shall contain only information appearing upon the books, records, documents and papers of or relating to the insurer, its agents or other person or affairs being examined, or ascertained from testimony of its officers, agents or other individuals under oath concerning the affairs of that insurer or person, together with any conclusions and

recommendations as may reasonably be warranted by the information.

(c) Upon receipt of the verified report the commissioner shall transmit the report to the insurer examined, together with a notice which shall afford the insurer examined a reasonable opportunity of not more than thirty (30) days to make a written submission or rebuttal with respect to any matters contained in the examination report. Upon written request by the insurer filed within the thirty (30) day period, the commissioner shall grant a hearing on the report and shall not file the report until after the hearing and after any appropriate modifications to the report.

(i) Repealed by Laws 1993, ch. 134, § 2.

(ii) Repealed by Laws 1993, ch. 134, § 2.

(d) Repealed by Laws 1993, ch. 134, § 2.

(e) Repealed by Laws 1993, ch. 134, § 2.

(f) Within thirty (30) days of the end of the period allowed for the receipt of written submissions or rebuttals or within thirty (30) days after conclusion of a hearing held pursuant to subsection (c) of this section, the commissioner shall fully consider and review the report, together with any written submissions or rebuttals and any relevant portions of the examiner's work papers and enter an order:

(i) Adopting the examination report as filed or with modification or corrections. If the examination report reveals that the insurer is operating in violation of any law, regulation or prior order of the commissioner, the commissioner may order the company to take any action the commissioner considers necessary and appropriate to cure the violation;

(ii) Rejecting the examination report with directions to the examiners to reopen the examination for purposes of obtaining additional data, documentation or information, and refiling pursuant to this section; or

(iii) Calling for an investigatory hearing with no less than twenty (20) days notice to the company for purposes of obtaining additional documentation, data, information and testimony.

(g) All orders entered pursuant to paragraph (f)(i) of this section shall be accompanied by findings and conclusions resulting from the commissioner's consideration and review of the examination report, relevant examiner work papers and any written submissions or rebuttals. Any such order shall be considered a final administrative decision and may be appealed pursuant to the Wyoming Administrative Procedure Act and shall be served upon the insurer by certified mail, together with a copy of the adopted examination report. Within thirty (30) days of the issuance of the adopted report, the company shall file affidavits executed by each of its directors stating under oath that they have received a copy of the adopted report and related orders.

(h) Notwithstanding any other provision of this code any hearing conducted under paragraph (f)(iii) of this section by the commissioner or authorized representative, shall be conducted as a nonadversarial confidential investigatory proceeding as necessary for the resolution of any inconsistencies, discrepancies or disputed issues apparent upon the face of the filed examination report or raised by or as a result of the commissioner's review of relevant work papers or by the written submission or rebuttal of the insurer. The hearing shall proceed expeditiously with discovery by the insurer limited to the examiner's work papers which tend to substantiate any assertions set forth in any written submission or rebuttal. The hearing shall proceed with the commissioner or his representative posing questions to the persons subpoenaed. Thereafter the insurer and the department may present testimony relevant to the investigation. Cross examination shall be conducted only by the commissioner or his representative. The insurer and the department shall be permitted to make closing statements and may be represented by counsel of their choice. The commissioner shall not appoint an examiner as an authorized representative to conduct the hearing but may exercise all other powers granted to him in the conduct of hearings under this code. Within twenty (20) days of the conclusion of any such hearing, the commissioner shall enter an order pursuant to paragraph (f)(i) of this section.

(j) Upon the adoption of the examination report under paragraph (f)(i) of this section, the commissioner shall continue to hold the content of the examination report as private and confidential information for a period of thirty (30) days except to the extent provided in subsection (c) of this section. Thereafter, the commissioner may open the report for

public inspection so long as no court of competent jurisdiction has stayed its publication.

(k) Nothing contained in W.S. 26-2-116 through 26-2-124 shall require the department to disclose any information or records which would indicate or show the existence or content of any investigation or activity of a criminal justice agency. Nothing contained in this code shall prevent or be construed as prohibiting the commissioner from disclosing the content of an examination report, preliminary examination report or results, or any matter relating thereto, as authorized by and in accordance with the provisions of W.S. 26-2-113(d). In the event the commissioner determines that regulatory action is appropriate as a result of any examination, he may initiate any proceedings or actions as provided by law. The provisions of W.S. 26-2-116 through 26-2-124 with regard to release of information shall prevail should any conflict arise between this act and W.S. 16-4-201 through 16-4-205.

(m) All working papers, recorded information, documents and copies thereof produced by, obtained by or disclosed to the commissioner or any other person in the course of an examination made under W.S. 26-2-116 through 26-2-124, or in the course of analysis by the commissioner of the financial condition or market conduct of a company, shall be given confidential treatment and are not subject to subpoena and shall not be made public by the commissioner or any other person, except to the extent provided in subsections (j) and (k) of this section.

26-2-122. Examinations; expense.

(a) The reasonable and proper expense of examination of an insurer or of any person referred to in W.S. 26-2-117(a)(ii) or (iv) shall be borne by the person examined, unless the expense has been otherwise provided for by the insurer having paid the assessment established by W.S. 26-2-204. The expense shall include the reasonable and proper expenses of the commissioner and his examiners, and a reasonable per diem as to such examiners, as necessarily incurred in the examination.

(b) The person examined shall promptly pay the examination expense upon the commissioner's presentation of a reasonably detailed written account thereof. The commissioner shall file a copy of the account in the department as a public record.

26-2-123. Witnesses; evidence; subpoenas.

(a) In any examination or investigation the department conducts, the commissioner or any representative he appoints may:

(i) Administer oaths and affirmations;

(ii) Examine and cross-examine witnesses;

(iii) Receive oral and documentary evidence;

(iv) Subpoena witnesses and compel their attendance and testimony; and

(v) Require by subpoena the production of any books, papers, records, files, correspondence, documents and other evidence deemed relevant to the inquiry whether under control of the department, the insurer or other persons.

(b) If any individual refuses to comply with any subpoena or to testify as to any matter concerning which he is lawfully interrogated, the district court of the county in which the examination or investigation is being conducted or in which the individual resides or may be found, on the commissioner's application, may issue an order requiring the individual to comply with the subpoena and testify or produce the evidence subpoenaed. Failure to obey a court order may be punished by the court as contempt.

(c) Subpoenas shall be served and proof of service made in the same manner as if issued by a district court. Witness fees and mileage, if claimed, shall be allowed the same as for testimony in court.

26-2-124. Immunity from prosecution when testimony is compelled; exception for perjury; waiver of immunity.

(a) If any person asks to be excused from attending or testifying or from producing any books, papers, records, correspondence, documents or other evidence in connection with any examination, investigation or hearing the commissioner or his representative conducts, or in any proceeding or action before any court or magistrate upon a charge of violation of this code, on the ground that the testimony or evidence required of him may tend to incriminate him or subject him to a penalty or forfeiture, and, notwithstanding, is directed by the commissioner and the attorney general to give the testimony or produce the evidence, he shall comply with that direction. The

person shall not thereafter be prosecuted or subjected to any penalty or forfeiture for or because of any transaction, matter or thing concerning which he may have testified or produced evidence, and no testimony given or evidence produced shall be received against him upon any criminal action, investigation or proceeding, except that no person so testifying is exempt from prosecution or punishment for perjury.

(b) Any person may execute, acknowledge and file in the department a statement expressly waiving the immunity or privilege in respect to any transaction, matter or thing specified in the statement. The testimony of that person or the evidence in relation to the transaction, matter or thing may then be received or produced before any judge or justice, court, tribunal, magistrate, grand jury or otherwise, and if so received or produced the person is not entitled to any immunity or privileges because of any testimony he gives or evidence he produces.

26-2-125. Commissioner's hearings; generally; when required; request for hearing; stay.

(a) The commissioner may hold a hearing without request by others for any purpose within the scope of this code.

(b) The commissioner shall hold a hearing:

(i) If required by this code or the Wyoming Administrative Procedure Act; or

(ii) Upon written request therefor by a person aggrieved by any act, threatened act or failure of the commissioner to act, or by any report, rule, regulation or order of the commissioner, other than an order for the holding of a hearing, or an order on a hearing or pursuant to the order, of which the person had notice.

(c) Any request for hearing shall be filed in the department within ninety (90) days after the person knows or reasonably should know of the act, threatened act, failure, report or order, unless a different period is provided for by other laws applicable to a particular matter, in which case the other law governs. A hearing as to the legality of a rule or regulation may be requested within ninety (90) days after the person knows or reasonably should know of the application or proposed application of the rule or regulation as to the person in a particular instance.

(d) Any request for hearing shall summarize the information and grounds to be relied upon as a basis for the relief to be sought at the hearing.

(e) If the commissioner finds that the request is made in good faith, that the person would be aggrieved if his grounds are established and that the grounds otherwise justify the hearing, he shall hold the hearing within thirty (30) days from the date the request is filed, unless postponed by mutual consent. Failure to hold the hearing upon request of a person entitled thereto as provided in this section constitutes a denial of the relief sought and is the equivalent of a final order of the commissioner for the purpose of an appeal under W.S. 26-2-129.

(f) Any request for hearing the commissioner receives prior to the effective date of action he takes or proposes to take stays the action pending the hearing, except as to action taken or proposed under an order:

(i) On hearing;

(ii) Pursuant to an order on hearing;

(iii) To make good an impairment of the capital funds of an insurer; or

(iv) Made pursuant to chapter 14 of this code.

(g) If an automatic stay is not provided for, and if the commissioner after written request therefor fails to grant a stay, the person aggrieved may apply to the district court of Laramie county for a stay of the commissioner's action.

26-2-126. Commissioner's hearings; notice of hearing; contents; delivery.

(a) Unless a longer period is expressly provided in this code, the commissioner shall give written notice of the hearing not less than ten (10) days in advance. If the persons to be given notice are not specified in the provision pursuant to which the hearing is held, the commissioner shall give notice to all persons whose financial interests the hearing directly and immediately affects.

(b) If any person is entitled to a hearing by any provision of law before any proposed action is taken, the notice of the hearing may be in the form of a notice to show cause stating:

(i) That the proposed action may be taken unless the person shows cause at a hearing to be held as specified in the notice why the proposed action should not be taken; and

(ii) The basis of the proposed action.

(c) Notice of hearing shall otherwise be in accordance with W.S. 16-3-107, except that mailed notice is deemed to have been served when addressed to the person to be notified at his address last of record with the department and deposited, postage paid, in a mail depository of the United States post office.

26-2-127. Commissioner's hearings; procedure.

(a) The commissioner shall allow any party to the hearing to:

(i) Appear in person and by counsel;

(ii) Be present during the giving of all evidence;

(iii) Have a reasonable opportunity to inspect all documentary and other evidence;

(iv) Examine and cross-examine witnesses;

(v) Present evidence in support of his interest; and

(vi) Have subpoenas issued by the commissioner to compel attendance of witnesses and production of evidence in his behalf.

(b) Upon good cause shown the commissioner shall permit to become a party to the hearing by intervention, if timely, only those persons who were not original parties thereto and whose pecuniary interests are to be directly and immediately affected by the commissioner's order made upon the hearing.

(c) Hearings in other respects are subject to the Wyoming Administrative Procedure Act as to contested cases.

26-2-128. Commissioner's hearings; commissioner's orders after hearing.

(a) Within thirty (30) days after termination of a hearing, or within sixty (60) days after termination if a transcript of the proceedings is to be made, or of any rehearing or reargument thereof, or within any other period as may be specified in this code as to particular matters, or within any further period to which the parties consent in writing, the commissioner shall make and enter his order on hearing. Failure of the commissioner to make and enter his order within the period allowed is deemed a denial of the petition, relief or application as to which the hearing was held.

(b) The commissioner shall promptly give a copy of the order to each party to the hearing in the same manner as notice of the hearing was given, except that as to hearings held concerning merger, consolidation, bulk reinsurance or conversion of a domestic insurer as provided for in chapter 24 or in chapter 27 of this code, if notice of the hearing was mailed or given to all stockholders or policyholders, or both, of the insurer or insurers involved, the commissioner is required to give a copy of the order to the corporate or insurer parties, to intervening parties, to a reasonable number of the stockholders or policyholders as representative of the class and to other parties only upon written request of those parties.

(c) The orders are otherwise subject to the Wyoming Administrative Procedure Act as in contested cases.

26-2-129. Commissioner's hearings; appeals; procedure; injunctions.

(a) An appeal shall be taken only:

(i) From the commissioner's order on hearing; or

(ii) As to a matter on which the commissioner fails to:

(A) Hold a hearing after application therefor under W.S. 26-2-125; or

(B) Make and enter his order on hearing as required by W.S. 26-2-128.

(b) All such appeals shall be taken as provided by the Wyoming Administrative Procedure Act for contested cases.

(c) This section does not prohibit recourse to injunction or other appropriate emergency proceedings in proper circumstances.

26-2-130. Cease and desist authority.

(a) The commissioner may issue a cease and desist order if:

(i) It appears from specific facts shown by affidavit that a person, as defined by W.S. 26-1-102(a)(xx), is engaging in any act or practice prohibited under this code which is causing or can be reasonably expected to cause significant, imminent and irreparable injury to the insuring public; and

(ii) That the department has either discussed the matter with the person or has made a good-faith attempt to do so.

(b) Upon issuance of a cease and desist order, the commissioner shall serve upon the person affected by the order, by personal service as defined in rule 4 of the Wyoming Rules of Civil Procedure, or by registered or certified mail, return receipt requested, to the person's last known address, an order specifically stating the acts complained of and requiring the person to immediately cease and desist from the act, methods or practices stated. The cease and desist order shall have full force and effect as soon as it is received unless stayed by the commissioner pursuant to subsection (d) of this section. The cease and desist order shall be of no effect at the end of the second business day following its issuance unless the commissioner shall have obtained a temporary restraining order, pursuant to rule 65 of the Wyoming Rules of Civil Procedure or the person receiving the order shall have stipulated that it remain in effect pursuant to terms and conditions agreed upon by the commissioner and that person. Thereafter, the commissioner may seek such further orders of the court to enforce the cease and desist order as he deems appropriate or necessary. If a temporary restraining order is sought in accordance with this subsection, the cease and desist order shall remain in effect until the temporary restraining order or any extension thereof is denied, or until the cease and desist order is modified or stayed by an order of the court. The action seeking the temporary restraining order shall be filed in the district court

for Laramie county or in the district court for the county in which person affected by the order resides or has his principal place of business.

(c) If the person affected by the cease and desist order seeks to contest the order, the person shall request a hearing before the commissioner not later than ten (10) days after the date on which the person received the order. A request to contest an order shall be in writing, served upon the commissioner by personal service as defined in rule 4 of the Wyoming Rules of Civil Procedure, or by registered or certified mail, and shall state the grounds for the request to set aside or modify the order.

(d) On receiving the request for a hearing, the commissioner shall serve notice of the time and place of the hearing at which the person requesting the hearing shall have the opportunity to show cause why the order should not be affirmed. The hearing shall be held within ten (10) days from the date the request for hearing is received unless mutually waived by the parties or continuance granted by the commissioner for good cause. The cease and desist order shall continue in full force and effect while the hearing is pending unless the order is stayed by the commissioner.

(e) The hearing on the order shall be conducted according to the procedures for contested cases under the Wyoming Administrative Procedure Act.

(f) Within two (2) working days after the hearing, the commissioner shall affirm, modify or set aside, in whole or in part, the cease and desist order.

(g) A cease and desist order shall be final eleven (11) days after the date the order is received by the person if a hearing as provided by subsection (c) of this section is not requested by the person affected by the order.

(h) Any person violating a cease and desist order issued under this section shall be assessed a civil penalty as provided by W.S. 26-1-107(b). If the commissioner reasonably believes that a person has violated a cease and desist order issued under this section, the commissioner may initiate judicial proceedings to enjoin further violation of the order in the district court for Laramie county or in the district court for the county in which the person resides or has his principal place of business.

(j) The commissioner may promulgate reasonable rules and regulations to carry out the purpose of this section.

(k) Any final order, ruling, finding, decision or other act of the commissioner made pursuant to this chapter or this section shall be subject to judicial review in accordance with the Wyoming Administrative Procedure Act.

26-2-131. Immunity from liability.

(a) No cause of action shall arise nor shall any liability be imposed against the commissioner, the commissioner's authorized representatives or any examiner appointed by the commissioner for any statements made or conduct performed in good faith while carrying out an examination or related activity under the provisions of this chapter.

(b) No cause of action shall arise nor shall any liability be imposed against any person for the act of communicating or delivering information or data to the commissioner, the commissioner's authorized representative or examiner or law enforcement agencies pursuant to an examination made under this chapter or any other criminal investigation under title 6 of the Wyoming statutes, if the act of communication or delivery was performed in good faith and without fraudulent intent.

(c) Any person identified in subsection (a) or (b) of this section shall be entitled to an award of attorney's fees and costs if he is a prevailing party in a civil cause of action for libel, slander or any other relevant tort arising out of activities in carrying out an examination or related activity under the provisions of this chapter and the party bringing the action was not substantially justified in doing so. For purposes of this section, a proceeding is "substantially justified" if it had a reasonable basis in law or fact at the time it was initiated.

26-2-132. Repealed by Laws 2022, ch. 55, § 2.

26-2-133. Disclosure of nonpublic personal information; rulemaking; rulemaking authority limited.

(a) The commissioner is authorized to adopt rules necessary to govern the practices of all persons licensed under this code with respect to the disclosure of nonpublic personal financial and health information of insurance consumers and customers. The rules shall prohibit the disclosure of any

nonpublic personal information contrary to the provisions of title V of the Gramm-Leach-Bliley Act of 1999, P.L. 106-102.

(b) Repealed By Laws 2007, Ch. 43, § 1.

26-2-134. Limiting the use of credit scoring; rulemaking.

(a) The commissioner is authorized to adopt rules as necessary to govern the practices of all persons licensed under this code with respect to the use of credit scoring in the underwriting of personal lines, motor vehicles and homeowner policies. The rules shall provide:

(i) That a person's credit history or scoring shall not be the sole basis to cancel, deny or nonrenew an insurance policy. An insurer may use credit history only in combination with other valid underwriting factors independent of credit history or score;

(ii) That an insurer shall provide notice to the person when credit scoring is being used to underwrite a policy and when use of credit scoring is adverse to the person;

(iii) That the consumer is adequately protected against unfair discrimination in the use of credit scoring to underwrite policies.

ARTICLE 2 - FUNDING

26-2-201. Deposit of fees.

The state treasurer shall place all fees received by the commissioner as provided in W.S. 26-2-205(c) in the state general fund.

26-2-202. Expenditures of the department.

The state treasurer shall make payments on warrants drawn by the state auditor, upon vouchers issued and signed by the commissioner or his designee, for expenditures required to carry out the functions of the department pursuant to the appropriations authorized the department by law.

26-2-203. Repealed by Laws 2017, ch. 9, § 3.

26-2-204. Insurers assessed for department expenditures.

(a) In addition to any other tax, license or fee imposed by law, each authorized insurer shall pay to the commissioner on or before June 1 of each year a fee for the privilege of transacting the business of insurance in this state, computed as follows:

(i) On or before April 1 of each year, the commissioner, with the governor's approval, shall estimate the expenditures of the department for the fiscal year commencing July 1, including the expense of any regularly scheduled association, zone, triannual or similar periodic statutorily scheduled financial examination of any authorized insurer, provided that neither the actual expenditures nor estimated expenditures of a fiscal year within the same biennial budget for the department shall not exceed the amount appropriated to the department by law; and

(ii) The commissioner shall then divide the estimated amount of expenditures, after deducting therefrom any expected unexpended funds in the account of the insurance department, by the total number of insurers then authorized to transact insurance in this state as of December 31 of the immediately preceding year. The result of this computation is the amount of the fee the commissioner shall assess each insurer.

(b) Upon receiving a statement of assessment from the commissioner, each authorized insurer shall promptly pay the fee to the commissioner.

26-2-205. Time for payment; penalties.

(a) If any insurer does not pay the assessment on or before June 1 of the year in which assessed or as otherwise ordered pursuant to W.S. 26-2-208, the assessment is delinquent. If the assessment is delinquent, the commissioner may suspend or revoke the insurer's certificate of authority.

(b) The suspension shall continue until the assessment is paid together with an additional fee of ten dollars ($10.00) for each day the fee remains delinquent after June 1. The penalty for late payment is in addition to any other penalties provided by this code.

(c) The commissioner shall deposit all sums collected under this section with the state treasurer for credit to the general fund.

26-2-206. Newly authorized insurers.

(a) Any insurer becoming first authorized after December 31 shall pay to the commissioner the amount determined pursuant to W.S. 26-2-204 prior to the commissioner issuing it a certificate of authority. The commissioner shall deposit the fee as provided by W.S. 26-2-204.

(b) This section does not apply to any insurer first authorized after December 31, 1987, but before March 31, 1988.

26-2-207. Other powers unaffected.

Nothing in this article alters or amends the commissioner's authority, obligations or duties under W.S. 26-2-116 through 26-2-125, nor does this article exempt an insurer examined by the department pursuant to W.S. 26-2-116(b) from the payments required under W.S. 26-2-122(b).

26-2-208. Additional assessment authorized.

If it appears to the commissioner that the total amount of assessments actually collected will not equal the authorized expenditures of the department for any biennial appropriation period, with the governor's approval, he shall make any additional assessments upon authorized insurers which will eliminate the deficiency. Any additional assessments are subject to all provisions of this article as if they were original assessments under W.S. 26-2-204.

26-2-209. Deduction allowed for retaliation.

Notwithstanding any other law, if any domestic insurer is required to pay additional taxes or fees to some other jurisdiction because of this article under the color of a retaliatory statute or other similar law, the insurer may deduct the additional taxes or fees from the premium taxes otherwise payable under W.S. 26-4-103.

CHAPTER 3 - AUTHORIZATION OF INSURERS AND GENERAL REQUIREMENTS

ARTICLE 1 - IN GENERAL

26-3-101. Certificate of authority required.

(a) No person shall act as an insurer and no insurer shall transact insurance in this state unless authorized by a subsisting certificate of authority granted by the commissioner, except as to transactions expressly otherwise provided in this code.

(b) No insurer shall solicit insurance applications or otherwise transact insurance in another state or country, from offices or by personnel located in this state, unless it holds a subsisting certificate of authority granted by the commissioner authorizing it to transact the same kinds of insurance in this state.

26-3-102. When certificate not required.

(a) A certificate of authority is not required of an insurer for:

(i) Investigation, settlement or litigation of claims under its policies lawfully written in this state, or liquidation of its assets and liabilities, other than collection of new premiums, all resulting from its authorized operations in this state;

(ii) Transactions thereunder subsequent to issuance of a policy covering only subjects of insurance not resident, located or expressly to be performed in this state at time of issuance and lawfully solicited, written and delivered outside this state;

(iii) Transactions pursuant to coverages lawfully written under chapter 11 of this code;

(iv) Reinsurance, except as to domestic reinsurers.

(b) An insurer not transacting new insurance business in Wyoming but continuing collection of premiums on and servicing policies remaining in force as to residents of or risks located in Wyoming is transacting insurance in Wyoming for the purpose of premium tax requirements only and is not required to have a certificate of authority. This subsection does not apply to insurers which withdrew from Wyoming prior to May 21, 1955.

26-3-103. General qualifications for authority to transact business.

(a) To transact insurance in this state an insurer shall be in compliance with this code, and its charter powers and shall be an incorporated stock insurer, an incorporated mutual insurer or a reciprocal insurer of the same general type as may be formed as a domestic insurer under this code.

(b) No foreign insurer shall be authorized to transact insurance or business on the mutual assessment plan, stipulated premium plan or any similar plan in this state if that insurer does not maintain reserves as required by chapter 6 of this code as applicable to the kinds of insurance or business transacted, wherever transacted in the United States. This prohibition does not apply to mutual or reciprocal insurers doing business on the cash premium plan but providing for contingent liability of policyholders or subscribers.

26-3-104. Insurers not qualified to transact business in state; credit and investigation reports.

(a) No foreign insurer owned or controlled in any manner or degree by any government or governmental agency shall be authorized to transact insurance in Wyoming. Membership in a mutual insurer, or subscribership in a reciprocal insurer, or ownership of stock of an insurer by the alien property custodian or similar official of the United States, or ownership of stock or other security which does not have voting rights with respect to the insurer's management, or supervision of an insurer by public authority, is not ownership or control of the insurer for the purposes of this subsection.

(b) The commissioner shall not grant or continue authority to transact insurance in this state as to any insurer the management of which, after investigation or upon reliable information, he finds:

(i) Is incompetent or untrustworthy;

(ii) So lacking in insurance company managerial experience as to make a proposed operation hazardous to the insurance-buying public; or

(iii) Is affiliated through ownership, control reinsurance or other insurance or business relations with any person whose business operations are or have been marked by manipulation of assets, accounts or reinsurance, or by bad faith.

(c) Before granting a certificate of authority to a new domestic insurer, the commissioner shall secure a credit and investigation report as to the insurer's management personnel and directors from a recognized and established independent investigation and reporting agency. The commissioner may secure a similar report relative to the management of any other insurer at any time he deems advisable.

26-3-105. Qualification of new foreign insurers.

(a) No foreign insurer is authorized to transact insurance in Wyoming if that insurer has not been issuing its own policies as an authorized insurer for at least two (2) years, unless the insurer is otherwise qualified for a certificate of authority under this code and is:

(i) The wholly owned subsidiary or affiliate of an insurer which is already an authorized insurer in Wyoming and the subsidiary or affiliate shares common management and business operations with the insurer;

(ii) The successor in interest through statutory merger or statutory consolidation, or through bulk reinsurance of substantially all of the insurance risks in this state, of an authorized insurer; or

(iii) An insurer seeking authority to write a line of insurance for which, in the commissioner's opinion:

(A) Adequate provision is not made by insurers already authorized in this state; or

(B) Adequate competition between insurers does not exist in this state.

(b) No foreign insurer shall continue to hold a certificate of authority under W.S. 26-3-114 if the insurer has reinsured substantially all of its insurance risks either prior to, contemporaneously with or after being acquired by another insurer not holding a subsisting certificate of authority in this state.

26-3-106. Conflict of names prohibited.

(a) No insurer shall be formed or authorized to transact insurance in this state if that insurer has or uses a name which:

(i) Is the same as or deceptively similar to that of another insurer already authorized;

(ii) In the case of a life insurer is deceptively similar to that of another insurer authorized to transact insurance in this state within the immediately preceding ten (10) years, if life insurance policies originally issued by the other insurer are still outstanding in this state;

(iii) Is the same as or deceptively similar to the name of any foreign insurer not so authorized if the foreign insurer has within the immediately preceding twelve (12) months signified its intention to secure an incorporation in this state under that name or to do business as a foreign insurer in this state under that name by filing notice of intention with the commissioner, unless the foreign insurer gives written consent to the use of the name or deceptively similar name; or

(iv) Tends to deceive or mislead as to the insurer's type of organization.

(b) In case of conflict of names between two (2) insurers, or a conflict otherwise prohibited under this section, the commissioner may permit, or shall require as a condition to the issuance of a certificate of authority to an applicant insurer, the insurer to use in this state a modified name as may reasonably be necessary to avoid the conflict.

26-3-107. Insurer may be authorized to transact combination of kinds of insurance; exceptions.

(a) A qualified insurer may be authorized to transact one (1) or more kinds of insurance as defined in chapter 5 of this code, except:

(i) A life insurer may grant annuities and may be authorized to transact disability insurance, except that the commissioner may continue to authorize any qualified life insurer which immediately prior to January 1, 1968 was lawfully authorized to transact in this state any kinds of insurance in addition to life and disability insurances and annuity business;

(ii) A reciprocal insurer shall not transact life insurance;

(iii) A title insurer shall be a stock insurer and shall not transact any other kind of insurance.

26-3-108. Capital and surplus requirements.

(a) To qualify for authority to transact any kind of insurance as defined in chapter 5 or combination of kinds of insurance as specified in this subsection, a foreign insurer, or a domestic stock insurer applying for its certificate of authority, shall possess and thereafter maintain unimpaired basic paid-in capital stock and surplus, if a stock insurer, or unimpaired basic surplus, if a foreign mutual insurer or foreign reciprocal insurer, in an amount not less than as follows:

Kind or kinds of insurance	Foreign Stock Insurers Capital Stock	Foreign Stock Insurers Surplus	Mutual Insurers Surplus	Reciprocal Insurers Surplus
Life	$1,000,000.	$500,000.	$1,500,000.	
Disability	1,000,000.	500,000.	1,500,000.	1,500,000.
Life & Disability	1,000,000.	1,000,000.	2,000,000.	
Property	1,000,000.	1,000,000.	2,000,000.	2,000,000.
Casualty Excluding Surety	1,000,000.	1,000,000.	2,000,000.	2,000,000.
Including Surety	1,000,000.	1,500,000.	2,500,000.	2,500,000.

Marine & Transportation	1,000,000.	1,000,000.	2,000,000.	2,000,000.
Multiple line (Property and any additional kind)	2,000,000.	2,000,000.	4,000,000.	4,000,000.
Title	500,000.	250,000.		

(b) Capital and surplus requirements are based upon all the kinds of insurance the insurer transacts in any areas in which it operates or proposes to operate, whether or not only a portion of the kinds are to be transacted in Wyoming.

(c) As to surplus required for qualification to transact one (1) or more kinds of insurance and thereafter to be maintained, domestic mutual insurers are governed by chapter 24 of this code and domestic reciprocal insurers are governed by chapter 27 of this code.

(d) The commissioner may require additional capital and surplus above the minimum capital and surplus requirements set forth in this section, or any other section of this code based upon the type, volume and nature of the insurance business transacted.

26-3-109. Delayed compliance with capital and surplus requirements.

(a) A domestic or foreign insurer holding a valid certificate of authority to transact insurance in this state as of April 1, 1985, may continue to transact the kinds of insurance permitted by the certificate of authority by complying with this code and by maintaining unimpaired not less than the same amount of paid-in capital stock or paid-in capital stock

and surplus, if a stock insurer, or not less than the same amount of surplus, if a mutual insurer, as required under the laws of this state for that authority immediately prior to that date, and as if the laws had continued in force.

(b) An insurer specified in subsection (a) of this section shall not be granted authority to transact any other or additional kinds of insurance unless it then fully complies with the capital and surplus requirements applied to all the kinds of insurance it then proposes to transact, as provided under W.S. 26-3-108 as to new domestic insurers.

26-3-110. Additional kinds of insurance authorized for certain insurers.

(a) Without additional capital or additional surplus, an authorized insurer is also authorized:

(i) If a life insurer, to grant annuities;

(ii) If a disability insurer, to insure against congenital defects as defined in W.S. 26-5-106(a)(xii);

(iii) If a casualty insurer, to transact also disability insurance;

(iv) If a property insurer, to include an amount and kind of insurance against legal liability for injury, damage or loss to the person or property of others, and for medical, hospital and surgical expense related to that injury, as the commissioner deems to be reasonably incidental to insurance of real property against fire and other perils under policies covering farm properties, or residential properties designed for occupancy by not more than four (4) families, with or without incidental office, professional, private school or studio occupancy by an insured, whether or not the premium or rate charged for certain perils so covered is specified in the policy.

(b) Paragraphs (a)(iii) and (iv) of this section do not apply to domestic insurers authorized pursuant to W.S. 26-3-109(a).

26-3-111. Deposit required of insurers.

(a) The commissioner shall not authorize an insurer to transact insurance in this state unless it makes and thereafter

continuously maintains in trust in this state through the commissioner, or in another state as provided in subsection (b) of this section, for the protection of all its policyholders and creditors a deposit of cash or securities eligible for deposit under W.S. 26-8-103 of a value not less than the amount applicable to the kinds of insurance the insurer transacts as follows:

Kind(s) of insurance	Minimum Amount of deposit
Life	$200,000.00
Disability	100,000.00
Life & disability	200,000.00
Property	100,000.00
Casualty	
Excluding surety	100,000.00
Including surety	150,000.00
Multiple line	200,000.00
Hail-crop	100,000.00
Title	
Domestic insurers	50,000.00
Foreign insurers	100,000.00

(b) As to foreign insurers, instead of the deposit or part thereof in this state, the commissioner shall accept the certificate in proper form of the public official having supervision over insurers in any other state to the effect that a like deposit or part thereof by the insurer is being maintained in public custody or control pursuant to law in the other state in trust for the protection of all its policyholders wherever located, or of all its policyholders in the United States, or all of its policyholders and creditors in the United States. All such deposits shall be in cash or securities, or

both, of a quality not less than those eligible for deposit in this state under W.S. 26-8-103.

(c) A property insurer also writing hail-crop coverages is required to have only the deposit applicable to property insurance. Instead of the hail-crop deposit, a domestic mutual hail-crop insurer, upon the commissioner's approval, may file with the commissioner and maintain reinsurance of all risk under all of the insurer's hail-crop policies. The reinsurer shall be qualified for a certificate of authority as a stock property insurer under this code, and the reinsurance agreement shall provide for payment by the reinsurer of one hundred percent (100%) of all losses under hail-crop policies issued by the ceding insurer without assessment of policyholders of the ceding insurer.

(d) All deposits in this state are subject to the applicable provisions of chapter 8 of this code.

(e) In addition to deposits required or maintained by foreign insurers, the commissioner may require any foreign insurer to make and maintain in trust in this state, through the commissioner, a deposit of cash or securities eligible for deposit under W.S. 26-8-103, of a value not less than an amount which the commissioner specifies, for the sole protection of an insurer's policyholders located in this state. All additional deposits are subject to the applicable provisions of chapter 8 of this code.

26-3-112. Certificate of authority; application; contents of application.

(a) An insurer shall apply to the commissioner for a certificate of authority, stating under oath of the president, or vice-president or other chief officer and the secretary of the insurer, or of the attorney-in-fact if the insurer is a reciprocal insurer, the insurer's name, location of its home office, or principal office in the United States if an alien insurer, the kinds of insurance to be transacted, date of organization or incorporation, form of organization, state or country of domicile and any additional information the commissioner reasonably requires. The application shall be accompanied by the applicable fees as provided in W.S. 26-4-101 together with the following documents, as applicable:

(i) If a corporation, a current, complete copy of its charter or articles of incorporation currently certified by the public official with whom the originals are on file;

(ii) If a domestic incorporated insurer or a mutual insurer, a current, complete copy of its bylaws, certified by the insurer's corporate secretary;

(iii) If a reciprocal insurer, a current, complete copy of the power of attorney of its attorney-in-fact, certified by the attorney-in-fact;

(iv) If a domestic reciprocal insurer, the declaration provided for in W.S. 26-27-107(b);

(v) A complete copy of its financial statement as of not earlier than the December 31 immediately preceding in "convention" form, sworn to by at least two (2) executive officers of the insurer or certified by the public insurance supervisory official of the insurer's state of domicile or of entry into the United States if an alien insurer;

(vi) A copy of the report of last examination made of the insurer as of a date within not more than the sixty (60) months immediately preceding, certified by the Wyoming insurance department or by the public insurance supervisory official of the insurer's state of domicile or state of entry into the United States if an alien insurer;

(vii) Acceptance of the constitution of the state of Wyoming, upon a form the commissioner furnishes for that purpose;

(viii) Appointment of the commissioner pursuant to W.S. 26-3-121 as its attorney to receive service of legal process;

(ix) If a foreign insurer a certificate:

(A) Of the public insurance supervisory official of its state or country of domicile showing that it is authorized to transact in that state or country the kinds of insurance proposed to be transacted in this state;

(B) As to deposit if to be tendered pursuant to W.S. 26-3-111(b).

(x) If an alien insurer, a copy of the appointment and authority of its United States manager, certified by its officer having custody of its records;

(xi) Repealed by Laws 2018, ch. 21, § 2.

(xii) Designation by the insurer of its officer or representative authorized to appoint and remove its agents in this state.

26-3-113. Certificate of authority; issuance; contents; delivery.

(a) If the commissioner finds that the insurer meets the certificate requirements under this code, he shall issue to the insurer a proper certificate of authority. If he finds the insurer does not meet the certificate requirements, the commissioner shall issue his order refusing the certificate. The commissioner shall act upon an application for certificate of authority within a reasonable period after its completion.

(b) The certificate, if issued, shall specify the kinds of insurance the insurer is authorized to transact in Wyoming. At the insurer's request the commissioner may issue a certificate of authority limited to particular types of insurance or coverages within the scope of a kind of insurance as defined in chapter 5 of this code.

(c) Repealed by Laws 2025, ch. 114, § 2.

26-3-114. Certificate of authority; continuation; expiration; reinstatement.

(a) A certificate of authority issued under this code continues in force until suspended or revoked by the commissioner or terminated at the insurer's request, subject to continuance by the insurer each year by:

(i) Payment prior to March 1 of the continuation fee provided in W.S. 26-4-101;

(ii) Filing by the insurer of its annual statement for the immediately preceding calendar year as required by W.S. 26-3-123; and

(iii) Payment by the insurer of premium taxes for the immediately preceding calendar year as required by W.S. 26-4-103.

(b) If not continued, an insurer's certificate of authority expires at midnight on May 31 immediately following the insurer's failure to continue it in force, unless earlier revoked for failure to pay taxes as provided in W.S. 26-4-105(b). The commissioner shall promptly notify the insurer of any impending expiration of its certificate of authority.

(c) The commissioner, upon the insurer's request made within three (3) months after expiration, may reinstate a certificate of authority which the insurer has permitted to expire, after the insurer has:

(i) Cured all failures which resulted in the expiration; and

(ii) Paid the reinstatement fee specified in W.S. 26-4-101.

(d) If an insurer fails to renew its certificate of authority within the time specified in subsection (c) of this section, another certificate shall be issued only after all requirements for a certificate of authority in this state are fulfilled.

(e) All insurers or persons otherwise licensed or registered under this article shall inform the commissioner by any means acceptable to the commissioner, or as specified by rule and regulation of the commissioner, of any change of address, telephone number, email address or other contact information that is on file with the department within thirty (30) days of the change.

26-3-115. Suspension, revocation of certificate of authority; mandatory grounds; hearing required.

(a) The commissioner shall refuse to continue or shall suspend or revoke an insurer's certificate of authority if:

(i) That action is required by any provision of this code;

(ii) A foreign insurer and it no longer meets the capital and surplus requirements specified in W.S. 26-3-108, or is otherwise unqualified;

(iii) A domestic insurer and it has failed to cure a capital or surplus impairment within the time the commissioner allows under this code, or is otherwise unqualified; or

(iv) The insurer's certificate of authority to transact insurance is suspended or revoked by its state of domicile, or state of entry into the United States if an alien insurer.

(b) Notwithstanding W.S. 16-3-113, in case of insolvency or impairment of required capital or surplus, or suspension or revocation by another state, the commissioner shall refuse, suspend or revoke the certificate of authority without a prior hearing. In all other cases the commissioner shall refuse, suspend or revoke the certificate of authority only after a hearing, unless the insurer waives the hearing in writing.

26-3-116. Suspension and revocation of certificate of authority; discretionary and special grounds.

(a) The commissioner may refuse to continue or may suspend or revoke an insurer's certificate of authority if he finds after a hearing that the insurer has:

(i) Violated or failed to comply with any lawful order of the commissioner;

(ii) Willfully violated or failed to comply with any lawful regulation of the commissioner; or

(iii) Violated any provision of this code other than those for violation of which suspension or revocation is mandatory.

(b) The commissioner shall suspend or revoke an insurer's certificate of authority on any of the following grounds if he finds after a hearing that the insurer:

(i) Is in unsound condition, or in such condition or using any methods and practices in the conduct of its business as to render its further transaction of insurance in this state injurious to policyholders or to the public;

(ii) With such frequency as to indicate its general business practice in this state has without just cause:

(A) Failed to pay claims arising under its policies, whether the claim is in favor of an insurer or is in favor of a third person with respect to the liability of an insured to that third person;

(B) Delayed payment of claims; or

(C) Compelled insureds or claimants to accept less than the amount due them, or to employ attorneys or to bring suit against the insurer or an insured to secure full payment or settlement of claims.

(iii) Is affiliated with and under the same general management, or interlocking directorate, or ownership as another insurer which transacts direct insurance in this state without having a certificate of authority therefor, except as permitted under this code;

(iv) Refuses to be examined, or if its directors, officers, employees or representatives refuse to:

(A) Submit to examination relative to its affairs;

(B) Produce its accounts, records and files for the commissioner's examination when required; or

(C) Perform any legal obligation relative to the examination.

(v) Failed to pay any final judgment rendered against it in this state upon any policy, bond, recognizance or undertaking issued or guaranteed by it, within thirty (30) days after the judgment became final, or within thirty (30) days after dismissal of an appeal before final determination, whichever date is later.

(c) In determining whether the continued operation of any insurer transacting insurance business in this state is hazardous or injurious to policyholders, creditors or the general public the commissioner may consider any of the following:

(i) Adverse findings reported in financial condition and market conduct examination reports, audit reports and actuarial opinions, reports or summaries;

(ii) The National Association of Insurance Commissioners' Insurance Regulatory Information System and its other financial analysis solvency tools and reports;

(iii) Repealed By Laws 2012, Ch. 38, § 3.

(iv) Whether the insurer has made adequate provision, according to presently accepted actuarial standards of practice, for the anticipated cash flows required by the contractual obligations and related expenses of the insurer, when considered in light of the assets held by the insurer with respect to such reserves and related actuarial items including, but not limited to, the investment earnings on such assets, and the considerations anticipated to be received and retained under such policies and contracts;

(v) The ability of any assuming reinsurer of the insurer to perform and whether the insurer's reinsurance program provides sufficient protection for the insurer's remaining surplus after taking into account the insurer's cash flow and the classes of business written and the financial condition of the assuming reinsurer;

(vi) Whether the insurer's operating loss in the last twelve (12) month period or any shorter period of time is greater than fifty percent (50%) of the insurer's remaining surplus as regards policyholders in excess of the minimum required. For purposes of this paragraph, "operating loss" shall include, but not be limited to net capital gain or loss, change in nonadmitted assets and cash dividends paid to shareholders;

(vii) Any affiliate's, subsidiary's, parent's, obligor's or reinsurer's insolvency, threatened insolvency or delinquency in payment of its monetary or other obligations and which in the opinion of the commissioner may affect the solvency of the insurer;

(viii) Contingent liabilities, pledges or guaranties which either individually or collectively involve a total amount which in the opinion of the commissioner may affect the solvency of the insurer;

(ix) The delinquency of any "controlling person" of an insurer in transmitting or paying net premiums to the insurer. For purposes of this paragraph, "controlling person" means any person who directly or indirectly has the power to direct the management, control or activities of the insurer;

(x) The age of receivables and the ability to collect receivables;

(xi) The failure of an insurer's management, including officers, directors, or any other person who directly or indirectly controls the operation of the insurer, to possess and demonstrate the competence, fitness and reputation necessary to serve the insurer in such position;

(xii) An insurer's management's failure to respond to inquiries relative to the condition of the insurer or an insurer's management's furnishing false and misleading information concerning an inquiry;

(xiii) An insurer's management's:

(A) Filing of any false or misleading sworn financial statement;

(B) Release of false or misleading financial statements to lending institutions or to the general public; or

(C) Making of a false or misleading entry, or omitting an entry of material amount in the books of the insurer.

(xiv) An insurer's rapid growth to such an extent that it lacks adequate financial and administrative capacity to meet its obligations in a timely manner;

(xv) An insurer's past or foreseeable future experience of cash flow or liquidity problems;

(xvi) Whether the insurer's operating loss in the last twelve (12) month period or any shorter period of time, excluding net capital gains, is greater than twenty percent (20%) of the insurer's remaining surplus as regards policyholders in excess of the minimum required;

(xvii) Whether the insurer has failed to meet financial and holding company filing requirements in the absence of a reason satisfactory to the commissioner;

(xviii) Whether management has established reserves that do not comply with minimum standards established by state insurance laws, regulations, statutory accounting standards, sound actuarial principles or standards of practice;

(xix) Whether management persistently engages in material underreserving that results in adverse development;

(xx) Whether transactions among affiliates, subsidiaries or controlling persons for which the insurer receives assets or capital gains, or both, do not provide sufficient value, liquidity or diversity to assure the insurer's ability to meet its outstanding obligations as they mature;

(xxi) Any other finding determined by the commissioner to be hazardous to the insurer's policyholders, creditors or general public.

(d) The standards set forth in subsection (c) of this section are in addition to those set forth in other laws or regulations of this state and shall not be construed to limit any other standards.

(e) The commissioner, without advance notice or hearing, may immediately suspend the certificate of authority of any insurer as to which proceedings for receivership, conservatorship, rehabilitation or other delinquency proceedings have been commenced in any state by the public insurance supervisory official of that state.

26-3-117. Suspension and revocation of certificate of authority; order and notice of suspension.

(a) All suspensions or revocations of or refusals to continue an insurer's certificate of authority shall be by the commissioner's order given to the insurer.

(b) Upon issuance of an order, the commissioner shall immediately give notice thereof to the insurer's agents in this state of record in the department and shall suspend or revoke the authority of those agents to represent the insurer.

(c) The commissioner shall publish notice of any suspension, revocation or refusal to continue in a newspaper in general circulation.

26-3-118. Suspension, revocation of certification of authority; duration of suspension; reinstatement.

(a) Suspension of an insurer's certificate of authority shall be for the period the commissioner specifies in the order of suspension, but not to exceed one (1) year. During the suspension period the commissioner may rescind or shorten the suspension by further order.

(b) During the suspension period the insurer shall not solicit or write any new business in this state but shall file its annual statement, pay fees, licenses and taxes as required under this code and may service its business already in force in this state as if the certificate of authority had continued in full force.

(c) Upon expiration of the suspension period, if within that period the certificate of authority has not terminated, the insurer's certificate of authority is automatically reinstated unless the commissioner finds that the causes of the suspension, other than a discontinued violation, have not terminated, or that the insurer is otherwise not in compliance with the requirements of this code, and of which the commissioner shall give the insurer notice not less than thirty (30) days in advance of expiration of the suspension period. If not automatically reinstated, the certificate of authority terminates at the end of the suspension period.

(d) Upon reinstatement of the insurer's certificate of authority, the authority of its agents in this state to represent the insurer also reinstate. The commissioner shall promptly notify the insurer and its agents in this state, of record in the department, of reinstatement. If pursuant to W.S. 26-3-117(c) the commissioner has published notice of suspension of the insurer's certificate of authority, he shall also publish notice of reinstatement.

26-3-119. General corporation laws not applicable to authorized foreign insurers.

The general corporation laws of this state do not apply to foreign insurers holding certificates of authority to transact insurance in this state.

26-3-120. Property insurance under 1 additional title authorized.

(a) A property insurer or multiple line insurer authorized to transact insurance in Wyoming may issue property insurance policies under its own name or under one (1) additional "title" registered with the commissioner.

(b) Upon request the commissioner shall furnish to the insurer the form required for registration, and the insurer shall pay the registration fee specified in W.S. 26-4-101. The registered title shall be shown on the insurer's certificate of authority and shall remain in effect as long as the insurer's certificate of authority is in effect, subject to earlier termination at the insurer's request.

(c) The insurer may separately appoint agents in this state under the registered title in the same manner and on payment of the same fees as apply to appointment and continuation of agents by property insurers in general.

(d) All business transacted by the insurer under the title shall be included in business and transactions of the insurer to be shown by its annual statement and for all purposes under this code.

26-3-121. Service of process; commissioner as agent for service.

(a) Before the commissioner issues a certificate of authority to any foreign, alien or domestic reciprocal insurer, each insurer shall appoint the commissioner, and his successors in office, as its attorney to receive service of legal process issued against the insurer in this state. The appointment shall be made on a form as designated and furnished by the commissioner and shall be accompanied by a copy of a resolution of the insurer's governing body, if an incorporated insurer, showing that the officers who executed the appointment were authorized to do so on the insurer's behalf.

(b) The appointment is irrevocable, binds the insurer and any successor in interest as to the insurer's assets or liabilities and remains in effect as long as there is in force any contract of the insurer in this state or any obligation of the insurer arising out of its transactions in this state.

(c) Service of process against a foreign or alien insurer shall be made only by service thereof upon the commissioner.

(d) At time of application for a certificate of authority the insurer shall file the appointment with the commissioner, together with a designation of the person to whom process against it served upon the commissioner is to be forwarded. The insurer may change that designation by a new filing.

26-3-122. Service of process; service generally.

(a) Service of process against an insurer for whom the commissioner is attorney shall be made by delivering to and leaving with the commissioner, his deputy or a person in apparent charge of his office during the commissioner's absence, two (2) copies of the process together with a fee as provided in W.S. 26-4-101, taxable as costs in the action.

(b) In case the process is issued by an inferior court, it may be directed to and served in duplicate by an officer authorized to serve process in the city or county of the commissioner's office, at least fifteen (15) days before the return day thereof, and that service confers jurisdiction.

(c) Upon service the commissioner shall immediately mail by certified mail one (1) of the copies of the process to the person currently designated by the insurer to receive the process as provided in W.S. 26-3-121(d).

(d) Service of process is sufficient if:

(i) Notice of that service and a copy of the process are sent within ten (10) days from the date of service by registered mail by plaintiff or his attorney to the defendant insurer at its last known principal place of business in the United States;

(ii) The defendant receives or the post office with which the letter is registered issues a receipt, showing the name of the sender of the letter and the name and address of the person to whom the letter is addressed; and

(iii) The affidavit of the plaintiff or his attorney showing compliance with this section are 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.

(e) The commissioner shall keep a record of the day of service upon him of all legal process.

(f) Process served upon the commissioner with a copy forwarded as in this section provided constitutes valid and binding personal service upon the insurer.

26-3-123. Annual and quarterly statement; required; form; verification; failure to file.

(a) Each authorized insurer, annually, on or before March 1, or within any extended time the commissioner grants, not to exceed thirty (30) days, shall file with the commissioner a full and true statement of its financial condition, transactions and affairs as of December 31 immediately preceding. The statement shall be in the general form and context of, and require information as called for by, the form of annual statement as currently in general and customary use in the United States for the type of insurer and kinds of insurance to be reported upon, with any modification the commissioner requires. The statement shall be verified by the oath of the insurer's president or vice-president and secretary or actuary as applicable, or if a reciprocal insurer by the oath of the attorney-in-fact, or its like officers if a corporation.

(b) Each authorized insurer shall file with the commissioner on a quarterly basis a statement of its financial condition for the preceding quarter. The statement shall be in the form of a quarterly statement as currently in general and customary use in the United States for the type of insurer and kinds of insurance to be reported upon, with any modification the commissioner requires. Each quarterly statement shall be filed with the commissioner on or before forty-five (45) days from the end of the quarter being reported.

(c) The statement of an alien insurer shall be verified by its United States manager or other authorized officer and shall relate only to the insurer's transactions and affairs in the United States unless the commissioner requires otherwise. If the commissioner requires a statement as to an alien insurer's affairs throughout the world, the insurer shall file the statement with the commissioner as soon as reasonably possible.

(d) All annual and quarterly statements filed pursuant to this section shall be completed pursuant to the most recent National Association of Insurance Commissioners' accounting

practices and procedures manual and accompanied by an electronic version containing the same information as the statement. The commissioner may specify the format of the electronic version. The commissioner may accept, for any foreign insurer required to file any statement under this section, an electronic filing with the National Association of Insurance Commissioners meeting the requirements of this section as a filing with the commissioner. The commissioner may refuse to continue or may suspend or revoke the certificate of authority of any insurer failing to file its annual or quarterly statement when due.

26-3-124. Annual statement; reporting of claims against health care providers; confidentiality; abstract of statistics.

(a) At the discretion of the commissioner and after notice provided under subsection (d) of this section, any insurer writing coverage for health care malpractice in this state, by March 1 of each year, may be required to file with the commissioner a report of all claims against a health care provider and a report of all awards or settlements given in cases against health care providers. The report shall contain the following information only for the preceding calendar year:

(i) The number and categories of all health care providers the company insures for professional liability;

(ii) The number of claims for which a reserve has been established made against covered health care providers, including those claims in which no suit was filed;

(iii) The awards and settlements on health care professional liability claims, including the costs of defense;

(iv) For each claim:

(A) Specialty coverage of the insured;

(B) Nature and substance of the claim;

(C) Age of the claimant or plaintiff;

(D) After final disposition of the claim, the date and manner of disposition, whether by judgment, settlement, arbitration or otherwise, and an itemization of the amounts paid, if any, if reported separately or can be reasonably segregated or identified for:

(I) Medical and prescription costs;

(II) Economic damages;

(III) Noneconomic damages;

(IV) Defense attorneys fees, costs and expenses.

(E) Any additional information required by the commissioner.

(b) Any information provided the commissioner pursuant to this section shall be confidential including the names of health care providers and any records pertaining thereto. The commissioner shall prepare a summary of such information, in the aggregate if necessary to protect the identity of the health care provider or claimant, for inclusion in his annual report to the governor pursuant to W.S. 9-2-1014.

(c) The commissioner may adopt rules, regulations and reporting forms necessary to carry out the provisions of this section.

(d) The commissioner shall give insurers not less than three (3) months notice if the information in subsection (a) of this section will be required to be reported to the commissioner.

26-3-125. Annual statement; mandatory reporting of claims against governmental entity.

(a) On or before March 15 of each year, each insurer providing insurance to a governmental entity, as defined in W.S. 1-39-103(a)(i), shall file with the commissioner of insurance a report of the claims made against its insureds which have been closed during the immediately preceding calendar year. The report shall contain, but is not limited to, the following information:

(i) The total number of claims filed, broken down by category or type of claim;

(ii) The total amount paid in settlement or discharge of the claims for each type or category of claims;

(iii) The total amount of premiums received from insureds under this act;

(iv) The total number of insureds under this act whose liability insurance the insurer cancelled or refused to renew and the reasons therefor.

26-3-126. Annual statement; correction and publication of statements.

(a) As soon as reasonably possible after the insurer files its annual statement with the commissioner, the commissioner shall review the statement and require correction of any errors or omissions.

(b) After any corrections noted are made, the commissioner shall:

(i) Cause each statement filed to be condensed and summarized showing briefly but intelligibly the capital, assets, liabilities, income, expenditures and business each insurer does within this state;

(ii) Include in the summary his certificate, if true, that to the best of his knowledge and belief the insurer is in all respects in compliance with the insurance laws of this state;

(iii) Cause each summary and certificate to be directly accessible to the public via a link from the main page of the official department website.

(c) Repealed By Laws 2013, Ch. 135, § 2.

(d) The commissioner shall cause to be published no less than six (6) times per year and no more than twelve (12) times per year, in newspapers of general circulation within the state that meet the requirements of legal newspapers pursuant to W.S. 18-3-519, a public service announcement pertaining to insurance which shall include a description of how citizens may access information about licensed insurance companies on the official department website. The cost of the publications shall be shared equally among all insurers required to file an annual statement pursuant to W.S. 26-3-123 and each insurer shall pay its share of the cost of publication upon receipt of a statement from the department. The department shall report to the joint corporations, elections and political subdivisions interim

committee on or before July 1, 2015 concerning any public response to the public service announcements required by this subsection.

26-3-127. Repealed by Laws 2000, Ch. 19, § 2.

26-3-128. Repealed by Laws 2000, Ch. 19, § 2.

26-3-129. Repealed by Laws 2000, Ch. 19, § 2.

26-3-130. Retaliatory provisions against other states and countries.

(a) The commissioner shall impose upon any insurer, or upon the agent or representative of that insurer of any other state or any foreign country doing business in Wyoming the same taxes, licenses and other fees, in the aggregate, and the same fines, penalties, deposit requirements or other material requirements, obligations, prohibitions or restrictions as are imposed upon Wyoming insurers, or upon their agents or representatives, by the laws of any other state or any political subdivision thereof, or any country or any province or other political subdivision thereof.

(b) This section does not apply to:

(i) Application fees, examination fees, license fees, appointment fees and continuation fees for agents, adjusters or consultants;

(ii) Personal income taxes, ad valorem taxes on real or personal property nor to special purpose obligations or assessments imposed by another state in connection with particular kinds of insurance other than property insurance, except that the commissioner shall consider deductions, from premium taxes or other taxes otherwise payable, allowed because of real estate or personal property taxes paid in determining the propriety and extent of retaliatory action under this section; or

(iii) Life insurance premium taxes on that portion of a life insurance policy's annual premium exceeding one hundred thousand dollars ($100,000.00).

(c) For the purposes of this section:

(i) The domicile of an alien insurer, other than insurers formed under the laws of Canada, or a province thereof, is that state the insurer designates in writing and files with the commissioner at time of admission to this state and may be that state in which:

(A) The insurer is first authorized to transact insurance;

(B) Is located the insurer's principal place of business in the United States; or

(C) Is held the insurer's largest deposit of trusteed assets for the protection of its policyholders in the United States.

(ii) The domicile of an insurer formed under the laws of Canada or a province thereof is that province in which its head office is located.

(d) If the insurer does not make a designation as provided in subsection (c) of this section, its domicile is that state in which is located its principal place of business in the United States.

26-3-131. Disclosure of loss information; penalties.

(a) Any insurer writing property or casualty insurance in this state as defined in W.S. 26-5-104 and 26-5-106, shall provide the following information to the named insured within thirty (30) days of receipt of the insured's written request, but in no event more frequently than once in any twelve (12) month period:

(i) Information on claims involving the insured closed within the preceding two (2) years limited to the date and description of occurrence and amount of payments, if any;

(ii) Information on open claims involving the insured limited to the date and description of occurrence, amount of claim and amount of payment, if any;

(iii) Information on notices of occurrence involving the insured limited to the date and description of occurrence and amount of claim; and

(iv) The total amount of reserve on open claims provided no insurer shall be required to provide information on any reserve specifically applicable to or identifying any claim which is or may become subject to proceedings before state or federal courts.

(b) An insurer which elects to cancel or nonrenew any policy of insurance subject to this section, for any reason other than nonpayment of premium, shall cause to be delivered to the insured, at the time such notice of cancellation or nonrenewal is given, a brief statement advising the insured of his right to request the information required to be given under this section.

(c) Any insurer who violates this section is subject to monetary penalties or license revocation or suspension as provided by W.S. 26-1-107 and 26-3-116.

(d) Repealed By Laws 2004, Chapter 57, § 3.

26-3-132. Commissioner's authority.

(a) For the purposes of making a determination of an insurer's financial condition under this code, the commissioner may:

(i) Disregard any credit or amount receivable resulting from transactions with a reinsurer which is insolvent, impaired or otherwise subject to a delinquency proceeding;

(ii) Make appropriate adjustments, including disallowance, to asset values attributable to investments in or transactions with an insurer's parent company, subsidiaries or affiliates consistent with the NAIC Accounting Practices and Procedures Manual, state laws and regulations;

(iii) Refuse to recognize the stated value of accounts receivable if the ability to collect receivables is highly speculative in view of the age of the account or the financial condition of the debtor;

(iv) Increase the insurer's liability in an amount equal to any contingent liability, pledge or guarantee not otherwise included if there is a substantial risk that the insurer will be called upon to meet the obligation undertaken within the next twelve (12) month period.

(b) If the commissioner determines that the continued operation of the insurer licensed to transact business in this state may be hazardous or injurious to its policyholders, creditors or the general public, then the commissioner may, in addition to any other action permitted by this code, issue an order requiring the insurer to:

(i) Reduce the total amount of present and potential liability for policy benefits by purchasing reinsurance;

(ii) Reduce, suspend or limit the volume of business being accepted or renewed;

(iii) Reduce general insurance expenses and commission expenses by specified methods;

(iv) Increase the insurer's capital and surplus;

(v) Suspend or limit the declaration and payment of dividends by an insurer to its stockholders or to its policyholders;

(vi) File reports in a form acceptable to the commissioner concerning the market value of an insurer's assets;

(vii) Limit or withdraw from specified investments or discontinue specified investment practices to the extent the commissioner deems necessary;

(viii) Document the adequacy of premium rates in relation to the risks insured;

(ix) File, in addition to regular annual statements, interim financial reports in the form adopted by the National Association of Insurance Commissioners or in a format promulgated by the commissioner;

(x) Correct corporate governance practice deficiencies and adopt and utilize governance practices acceptable to the commissioner;

(xi) Provide a business plan to the commissioner in order to continue to transact business in the state;

(xii) Notwithstanding W.S. 26-14-102, 26-19-304, 26-21-109, 26-23-326 and 26-34-109, adjust rates for any nonlife insurance product written by the insurer that the commissioner

considers necessary to improve the financial condition of the insurer.

(c) Any insurer subject to an order under subsection (b) of this section may request a hearing to review that order as provided in W.S. 26-2-125. The notice of hearing shall be served upon the insurer pursuant to W.S. 26-2-126. The notice of hearing shall state the time and place of hearing and the conduct, condition or grounds upon which the commissioner based the order. Unless mutually agreed between the commissioner and the insurer, the hearing shall occur not less than ten (10) days nor more than thirty (30) days after notice is served and shall be either in Laramie County or in some other place convenient to the parties designated by the commissioner. Notwithstanding any other provision of law, the commissioner shall hold all hearings under this subsection privately, unless the insurer requests a public hearing, in which case the hearing shall be public.

(d) This section shall not be construed to limit the powers granted the commissioner by any other laws of this state.

26-3-133. Judicial review.

Any order or decision of the commissioner pursuant to this title shall be subject to review in accordance with the Wyoming Administrative Procedure Act, W.S. 16-3-101 through 16-3-115, at the instance of any party to the proceedings whose interests are substantially affected.

ARTICLE 2 - INSURANCE REGULATORY INFORMATION SYSTEM

26-3-201. Short title.

This article is known and may be cited as the "Insurance Regulatory Information System Act".

26-3-202. Immunity.

Members of the National Association of Insurance Commissioners, their duly authorized committees, subcommittees, and task forces, their delegates, National Association of Insurance Commissioners employees, and all others charged with the responsibility of collecting, reviewing, analyzing and disseminating the information developed by the National Association of Insurance Commissioners' Insurance Regulatory Information System from annual statements filed with the National Association of Insurance Commissioners convention

blanks shall be acting as agents of the commissioner under the authority of this article and in the absence of actual malice shall not be subject to civil liability for libel, slander or any other cause of action by virtue of their collection, review and analysis or dissemination of the data and information collected from the filings.

26-3-203. Confidentiality.

All financial analysis ratios and examination synopsis concerning insurance companies that are submitted to the department by the National Association of Insurance Commissioners' Insurance Regulatory Information System are confidential and shall not be disclosed by the department except as authorized by and in accordance with the provisions of W.S. 26-2-113(d).

26-3-204. Filing requirements; penalty.

(a) Each domestic, foreign or alien insurer authorized to transact insurance in this state shall annually on or before March 1, file with the National Association of Insurance Commissioners a copy of its annual statement convention blank along with such additional filings prescribed by the commissioner for the preceding year. The information filed with the National Association of Insurance Commissioners shall be in the same format and scope as that required by the commissioner and shall include the signed jurat page and the actuarial certification. Any amendments and addenda to the annual statement filing subsequently filed with the commissioner shall also be filed with the National Association of Insurance Commissioners. Each insurer shall concurrently provide the National Association of Insurance Commissioners with a copy of the electronic filing containing its annual statement as required by W.S. 26-3-123.

(b) Foreign insurers that are domiciled in a state which has a law substantially similar to subsection (a) of this section shall be deemed in compliance with this section.

(c) Each domestic, foreign or alien insurer authorized to transact insurance in this state shall quarterly on or before forty-five (45) days after the end of the quarter being reported, file with the National Association of Insurance Commissioners a copy of its quarterly statement blank. The information filed with the National Association of Insurance Commissioners shall be in the same format and scope as that

required by the commissioner and shall include the signed jurat page. Any amendments and addenda to the quarterly statement filing subsequently filed with the commissioner shall also be filed with the National Association of Insurance Commissioners. Each insurer shall concurrently provide the National Association of Insurance Commissioners with a copy of the electronic filing containing its quarterly statement as required by W.S. 26-3-123.

(d) The commissioner may impose a civil penalty pursuant to W.S. 26-1-107 and may suspend, revoke or refuse to renew the certificate of authority of any insurer failing to file its quarterly or annual statement when due or within any extension of time which the commissioner, for good cause, may have granted.

ARTICLE 3 - ANNUAL AUDITED FINANCIAL REPORTS LAW

26-3-301. Scope of article.

(a) Every insurer as defined by W.S. 26-1-102(a)(xvi) shall be subject to this article. Insurers having direct premiums written in this state of less than one million dollars ($1,000,000.00) in any calendar year and less than one thousand (1,000) policyholders or certificate holders of direct written policies nationwide at the end of a calendar year shall be exempt from this article for that year except an insurer shall not be exempt if:

(i) The commissioner makes a specific finding that compliance is necessary for the commissioner to carry out statutory responsibilities; or

(ii) The insurer has assumed premiums pursuant to contracts or treaties of reinsurance of one million dollars ($1,000,000.00) or more.

(b) Foreign or alien insurers filing the audited financial report in another state, pursuant to that state's requirement for filing of audited financial reports which has been found by the commissioner to be substantially similar to the requirements of this article, are exempt from W.S. 26-3-303 through 26-3-312 if:

(i) A copy of the audited financial report, communication of internal control related matters noted in an audit and the accountant's letter of qualifications which are filed with the other state are filed with the commissioner and a

copy of the audited financial report which is on file with the other state is filed with the National Association of Insurance Commissioners in accordance with the filing dates specified in W.S. 26-3-303, 26-3-310 and 26-3-311, respectively. Canadian insurers may submit accountants' reports as filed with the office of the superintendent of financial institutions, Canada; and

(ii) A copy of any notification of adverse financial condition report filed with the other state is filed with the commissioner within the time specified in W.S. 26-3-309.

(c) This article shall not prohibit, preclude or in any way limit the commissioner from ordering or conducting or performing examinations of insurers under this code or regulations and the practices and procedures of the department.

(d) Foreign or alien insurers required to file management's report of internal control over financial reporting in another state are exempt from filing the report in this state provided the other state has substantially similar reporting requirements and the report is filed with the commissioner of the other state within the time specified.

26-3-302. Definitions.

(a) As used in this article:

(i) "Accountant" or "independent certified public accountant" means an independent certified public accountant or accounting firm in good standing with the American Institute of Certified Public Accountants and in all states in which they are licensed to practice. For Canadian and British companies, the terms mean a Canadian-chartered or British-chartered accountant;

(ii) "Audited financial report" means and includes those items specified in W.S. 26-3-304;

(iii) "Indemnification" means an agreement of indemnity or a release from liability where the intent or effect is to shift or limit in any manner the potential liability of the person or firm for failure to adhere to applicable auditing or professional standards, whether or not resulting in part from knowing or other misrepresentations made by the insurer or its representatives;

(iv) "Insurer" means as defined in W.S. 26-1-102(a)(xvi);

(v) "Affiliate of" or "affiliated with" a specific person means a person that directly, or indirectly through one (1) or more intermediaries, controls or is controlled by or is under common control with the person specified;

(vi) "Audit committee" means a committee established by the board of directors of an entity for the purpose of overseeing the accounting and financial reporting processes of an insurer or group of insurers, the internal audit function of an insurer or group of insurers and external audits of financial statements of the insurer or group of insurers. The audit committee of any entity that controls a group of insurers may be deemed to be the audit committee for one (1) or more of these controlled insurers solely for the purposes of this regulation at the election of the controlling person. If an audit committee is not designated by the insurer, the insurer's entire board of directors shall constitute the audit committee;

(vii) "Independent board member" means as defined in W.S. 26-3-315(d);

(viii) "Internal control over financial reporting" means a process effected by an entity's board of directors, management and other personnel designed to provide reasonable assurance regarding the reliability of the financial statements and includes those policies and procedures that:

(A) Pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of assets;

(B) Provide reasonable assurance that transactions are recorded as necessary to permit preparation of the financial statements and that receipts and expenditures are being made only in accordance with authorizations of management and directors; and

(C) Provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of assets that could have a material affect on the financial statements.

(ix) "Group of insurers" means those licensed insurers included in the reporting requirements of W.S.

26-44-101 through 26-44-117 or a set of insurers as identified by management, for the purpose of assessing the effectiveness of internal control over financial reporting;

(x) "SEC" means the United States Securities and Exchange Commission;

(xi) "Section 404" means section 404 of the Sarbanes-Oxley Act of 2002 or subsequently enacted similar federal law and the SEC's rules and regulations promulgated thereunder;

(xii) "Section 404 report" means management's report on internal control over financial reporting as defined by the SEC and the related attestation report of the independent certified public accountant;

(xiii) "SOX compliant entity" means an entity that either is required to be compliant with or voluntarily is compliant with all of the following provisions of the Sarbanes-Oxley Act of 2002 or similar provisions of subsequently enacted similar federal law:

(A) The preapproval requirements of Section 201;

(B) The audit committee independence requirements of Section 301; and

(C) The internal control over financial reporting requirements of Section 404.

(xiv) "Internal audit function" means a person who provides independent oversight designed to improve an organization's operations and who accomplishes this oversight by using an objective approach to evaluate and improve risk management, control and corporate governance.

26-3-303. General requirements related to filing and extensions for filing of annual audited financial reports; audit committee appointment.

(a) All insurers shall have an annual audit by an independent certified public accountant and shall file an audited financial report with the commissioner on or before June 1 for the immediately preceding calendar year. The commissioner may require an insurer to file an audited financial report earlier than June 1 with ninety (90) days advance notice to the insurer.

(b) Extensions of the June 1 filing date may be granted by the commissioner for thirty (30) day periods upon a showing by the insurer and its independent certified public accountant of the reasons for requesting the extension and a determination by the commissioner there is good cause for an extension. The request for extension shall be submitted in writing not less than ten (10) days prior to the due date in sufficient detail to permit the commissioner to make an informed decision with respect to the requested extension.

(c) If an extension is granted in accordance with subsection (b) of this section, a similar extension of thirty (30) days is granted to the filing of the management's report of internal control over financial reporting.

(d) Every insurer required to file an annual audited financial report pursuant to this section shall designate a group of individuals as constituting its audit committee. The audit committee of an entity that controls an insurer may be deemed to be the insurer's audit committee for purposes of this article at the election of the controlling person.

26-3-304. Contents of annual audited financial report.

(a) The annual audited financial report shall report the financial position of the insurer as of the end of the most recent calendar year and the results of its operations, cash flows and changes in capital and surplus for that year in conformity with statutory accounting practices prescribed or permitted by the department of insurance of the state of domicile.

(b) The annual audited financial report shall include the following:

(i) Report of an independent certified public accountant;

(ii) Balance sheet reporting admitted assets, liabilities, capital and surplus;

(iii) Statement of operations;

(iv) Statement of cash flows;

(v) Statement of changes in capital and surplus;

(vi) Notes to financial statements. The notes shall be those required by the appropriate National Association of Insurance Commissioners' annual statement instructions and the most recent National Association of Insurance Commissioners' accounting practices and procedures manual. The notes shall include:

(A) A reconciliation of differences, if any, between the audited statutory financial statements and the annual statement filed pursuant to W.S. 26-3-123 with a written description of the nature of these differences;

(B) Repealed By Laws 2001, Ch. 9, § 2.

(vii) The financial statements included in the audited financial report shall be prepared in a form and using language and groupings substantially the same as the relevant sections of the annual statement of the insurer filed with the commissioner. The financial statement shall be comparative, presenting the amounts as of December 31 of the current year and the amounts as of the immediately preceding December 31.

26-3-305. Designation of independent certified public accountant.

(a) Each insurer required by this article to file an annual audited financial report shall within sixty (60) days after becoming subject to the requirement, register with the commissioner in writing the name and address of the independent certified public accountant or accounting firm retained to conduct the annual audit. Insurers not retaining an independent certified public accountant on or before April 1, 1994 shall register the name and address of their retained independent certified public accountant not less than six (6) months before the date when the first audited financial report is to be filed.

(b) The insurer shall obtain a letter from the accountant, and file a copy with the commissioner stating that the accountant is aware of the provisions of the insurance code and the rules and regulations of the insurance department of the state of domicile that relate to accounting and financial matters and affirming that he will express his opinion on the financial statements in terms of their conformity to the statutory accounting practices prescribed or otherwise permitted by that department, specifying the exceptions he believes appropriate.

(c) If an accountant who was the accountant for the immediately preceding filed audited financial report is dismissed or resigns, the insurer shall within five (5) business days notify the department of this event. The insurer shall also furnish the commissioner with a separate letter within ten (10) business days of the above notification stating whether in the twenty-four (24) months preceding the dismissal or resignation there were any disagreements with the former accountant on any matter of accounting principles or practices, financial statement disclosure, or auditing scope or procedure which, if not resolved to the satisfaction of the former accountant would have caused him to make reference to the subject matter of the disagreement in connection with his opinion. The disagreements required to be reported under this subsection include both those resolved to the former accountant's satisfaction and those not resolved to the former accountant's satisfaction. Disagreements required to be reported under this subsection are those which occur at the decision-making level, between personnel of the insurer responsible for presentation of its financial statements and personnel of the accounting firm responsible for rendering its report. The insurer shall also in writing request and the former accountant shall furnish a letter addressed to the department with a copy to the insurer stating whether the accountant agrees with the statements contained in the insurer's letter and, if not, stating the reasons for which he does not agree.

26-3-306. Qualifications of independent certified public accountant.

(a) The commissioner shall not recognize any person or firm as a qualified independent certified public accountant if that person or firm:

(i) Is not in good standing with the American Institute of Certified Public Accountants and in all states in which the accountant is licensed to practice, or, for a Canadian or British company, that is not a chartered accountant; or

(ii) Has either directly or indirectly entered into an agreement of indemnification with respect to the audit of the insurer.

(b) Except as otherwise provided in this section, the commissioner shall recognize an independent certified public

accountant as qualified as long as he conforms to the standards of his profession, as contained in the code of professional ethics of the American Institute of Certified Public Accountants and rules and regulations and code of ethics and rules of professional conduct of the Wyoming board of certified public accountants, or similar code.

(c) After January 1, 2010, the lead or coordinating audit partner having primary responsibility for the audit shall not act in that capacity for more than five (5) consecutive years. The person shall be disqualified from acting in that or a similar capacity for the same company or its insurance subsidiaries or affiliates for a period of five (5) consecutive years. An insurer may make application to the commissioner for relief from the rotation requirement on the basis of unusual circumstances. This application shall be made at least thirty (30) days before the end of the calendar year. The insurer shall file with its annual statement, the approval for relief pursuant to this subsection with the states in which it is licensed or doing business and with the NAIC. If the nondomestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC. The commissioner may consider the following factors in determining whether the relief should be granted:

(i) Number of partners, expertise of the partners or the number of insurance clients in the currently registered firm;

(ii) Premium volume of the insurer; or

(iii) Number of jurisdictions in which the insurer transacts business.

(d) The commissioner shall neither recognize as a qualified independent certified public accountant, nor accept any annual audited financial report, prepared in whole or in part by, any natural person who:

(i) Has been convicted of fraud, bribery, a violation of the Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. Sections 1961 through 1968, or any dishonest conduct or practices under federal or state law;

(ii) Has been found to have violated the insurance laws of this state with respect to any previous reports submitted under this article; or

(iii) Has demonstrated a pattern or practice of failing to detect or disclose material information in previous reports filed under the provisions of this article.

(e) The commissioner may hold a hearing to determine whether an independent certified public accountant is qualified and, considering the evidence presented, may rule that the accountant is not qualified for purposes of expressing his opinion on the financial statements in the annual audited financial report made pursuant to this article and require the insurer to replace the accountant with another whose relationship with the insurer is qualified within the meaning of this article.

(f) A qualified independent certified public accountant may enter into an agreement with an insurer to have disputes relating to an audit resolved by mediation or arbitration. However, in the event of a delinquency proceeding commenced against the insurer under chapter 28 of this code, the mediation or arbitration provisions shall operate at the option of the statutory successor.

(g) The commissioner shall neither recognize as a qualified independent certified public accountant, nor accept an annual audited financial report, prepared in whole or in part by an accountant who provides to an insurer, contemporaneously with the audit, the following nonaudit services:

(i) Bookkeeping or other services related to the accounting records or financial statements of the insurer;

(ii) Financial information systems design and implementation;

(iii) Appraisal or valuation services, fairness opinion or contribution-in-kind reports;

(iv) Actuarially-oriented advisory services involving the determination of amounts recorded in the financial statements. The accountant may assist an insurer in understanding the methods, assumptions and inputs used in the determination of amounts recorded in the financial statement only if it is reasonable to conclude that the services provided

will not be subject to audit procedures during an audit of the insurer's financial statements. An accountant's actuary may also issue an actuarial opinion or certification on an insurer's reserves if the following conditions have been met:

(A) Neither the accountant nor the accountant's actuary has performed any management functions or made any management decisions;

(B) The insurer has competent personnel or engages a third party actuary to estimate the reserves for which management takes responsibility; and

(C) The accountant's actuary tests the reasonableness of the reserves after insurer's management has determined the amount of the reserves.

(v) Internal audit outsourcing services;

(vi) Management functions or human resources;

(vii) Broker or dealer, investment adviser or investment banking services;

(viii) Legal services or expert services unrelated to the audit; or

(ix) Any other services that the commissioner determines by regulation to be impermissible. In determining whether other services are impermissible, the commissioner shall consider the principle that the accountant may not function in the role of management, may not audit his own work and may not serve in an advocacy role for the insurer.

(h) Insurers having direct written and assumed premiums of less than one hundred million dollars ($100,000,000.00) in any calendar year may request an exemption from subsection (g) of this section. The insurer shall file with the commissioner a written statement discussing the reasons why the insurer should be exempt from subsection (g) of this section. If the commissioner finds, upon review of the statement, that compliance with subsection (g) of this section would constitute a financial or organizational hardship on the insurer, an exemption may be granted.

(j) A qualified independent certified public accountant who performs the audit may engage in other nonaudit services,

including tax services, that are not described in subsection (g) of this section or that do not conflict with paragraph (g)(ix) of this section only if the activity is approved in advance by the audit committee in accordance with subsection (k) of this section.

(k) All auditing services and nonaudit services provided to an insurer by the qualified independent certified public accountant of the insurer shall be preapproved by the audit committee. The preapproval requirement shall be waived with respect to nonaudit services if the insurer is a SOX compliant entity or a direct or indirect wholly-owned subsidiary of a SOX compliant entity or if:

(i) The aggregate amount of all nonaudit services provided to the insurer constitutes not more than five percent (5%) of the total amount of fees paid by the insurer to its qualified independent certified public accountant during the fiscal year in which the nonaudit services are provided;

(ii) The services were not recognized by the insurer at the time of the engagement to be nonaudit services; and

(iii) The services are promptly brought to the attention of the audit committee and approved prior to the completion of the audit by the audit committee or by one (1) or more members of the audit committee who are the members of the board of directors to whom authority to grant such approvals has been delegated by the audit committee.

(m) The audit committee may delegate to one (1) or more designated members of the audit committee the authority to grant the preapprovals required under subsection (k) of this section. The decisions of any member to whom this authority is delegated shall be presented to the full audit committee at each of its scheduled meetings.

(n) The commissioner shall not recognize an independent certified public accountant as qualified for a particular insurer if a member of the board, president, chief executive officer, controller, chief financial officer, chief accounting officer or any person serving in an equivalent position for that insurer was employed by the independent certified public accountant and participated in the audit of that insurer during the one (1) year period preceding the date that the most current statutory opinion is due. This subsection shall only apply to partners and senior managers involved in the audit. An insurer

may make application to the commissioner for relief from this subsection on the basis of unusual circumstances. The insurer shall file with its annual statement filing the approval for relief under this subsection with the states that it is licensed in or doing business in and with the NAIC. If the nondomestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC.

26-3-307. Consolidated or combined audits.

(a) An insurer may make written application to the commissioner for approval to file audited consolidated or combined financial statements in lieu of separate annual audited financial statements if the insurer is part of a group of insurance companies which utilizes a pooling or one hundred percent (100%) reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer cedes all of its direct and assumed business to the pool. In those cases, a columnar consolidating or combining supplemental schedules shall be filed with the report, as follows:

(i) Amounts shown on the consolidated or combined audited financial report shall be shown on the supplemental schedules;

(ii) Amounts for each insurer subject to this section shall be stated separately;

(iii) Noninsurance operations may be shown on the supplemental schedules on a combined or individual basis;

(iv) Explanations of consolidating and eliminating entries shall be included;

(v) A reconciliation shall be included of any differences between the amounts shown in the individual insurer columns of the supplemental schedules and comparable amounts shown on the annual statements of the insurers.

26-3-308. Scope of audit and report of independent certified public accountant.

Financial statements furnished pursuant to W.S. 26-3-304 shall be examined by the independent certified public accountant. The audit of the insurer's financial statements shall be conducted in accordance with generally accepted auditing standards. In

accordance with Accumulation of Audit Standards (AU) Section 319 of the professional standards of the American Institute of Certified Public Accountants, Consideration of Internal Control in a Financial Statement Audit, the independent certified public accountant shall obtain an understanding of internal control sufficient to plan the audit. To the extent required by AU 319, for those insurers required to file a management's report of internal control over financial reporting pursuant to W.S. 26-3-318, the independent certified public accountant shall consider the most recently available report in planning and performing the audit of the statutory financial statements. Consideration shall be given to the procedures illustrated in the financial condition examiner's handbook promulgated by the National Association of Insurance Commissioners as the independent certified public accountant deems necessary.

26-3-309. Notification of adverse financial condition.

(a) An insurer required to furnish an annual audited financial report shall require the independent certified public accountant to report, in writing, within five (5) business days to the board of directors or its audit committee any determination supported by adequate research conducted by the independent certified public accountant:

(i) That the insurer has materially misstated its financial condition reported to the commissioner as of the balance sheet date currently under audit; or

(ii) That the insurer does not meet the minimum capital and surplus requirement of this code as of that date.

(b) An insurer which has received a report pursuant to subsection (a) of this section shall forward a copy of the report to the commissioner within five (5) business days of receipt of the report and shall provide the independent certified public accountant making the report with evidence of the report being furnished to the commissioner.

(c) Upon receiving the report from the insurer the commissioner shall notify the independent certified public accountant of his receipt of the report. The independent certified public accountant shall furnish the commissioner with a copy of the report within five (5) business days after the insurer is required to forward the report to the commissioner, unless the commissioner has previously acknowledged receipt of the report from the insurer.

(d) Except for any act constituting negligence or malpractice in the preparation of the annual audited financial report specified in W.S. 26-3-304, no independent certified public accountant shall be liable in any manner to any person for any statement made in connection with subsection (a) of this section if the statement is made in good faith in compliance with subsection (a) of this section.

(e) If the accountant, subsequent to the date of the audited financial report filed pursuant to this article, becomes aware of facts which might have affected his report, the accountant shall take the action prescribed in Volume 1, Section AU 561 of the Professional Standards of the American Institute of Certified Public Accountants, and other action as prescribed by the commissioner by rule.

26-3-310. Communication of internal control related matters noted in an audit.

In addition to the annual audited financial report, each insurer shall furnish the commissioner with a written communication as to any unremediated material weakness, as defined in statement on auditing standard 60 or its replacement, in its internal control over financial reporting noted by the accountant during the audit. Such communication shall be prepared by the accountant within sixty (60) days after the filing of the annual audited financial report and shall contain a description of any unremediated material weakness as of December 31 immediately preceding in the insurer's internal control over financial reporting noted by the accountant during the course of the audit of the financial statements. If no unremediated material weaknesses were noted, the communication shall so state. The insurer shall provide a description of remedial actions taken or proposed to correct unremediated material weaknesses, if the actions are not described in the accountant's communication.

26-3-311. Accountant's letter of qualifications.

(a) An accountant shall furnish the insurer in connection with, and for inclusion in, the filing of the annual audited financial report, a letter stating:

(i) That the accountant is independent with respect to the insurer and conforms to the standards of his profession as contained in the code of professional ethics and pronouncements of the American Institute of Certified Public

Accountants and the rules of professional conduct of the Wyoming board of certified public accountants, or similar code;

(ii) The background and experience in general, and the experience in audits of insurers of the staff assigned to the engagement and whether each is an independent certified public accountant. Nothing within this article shall be construed as prohibiting the accountant from utilizing staff as he deems appropriate where use is consistent with the standards prescribed by generally accepted auditing standards;

(iii) That the accountant understands the annual audited financial report and his opinion on the report will be filed in compliance with this article, and that the commissioner will be relying on this information in the monitoring and regulation of the financial position of insurers;

(iv) That the accountant consents to the requirements of W.S. 26-3-312, and that the accountant consents and agrees to make available for review by the commissioner, his designee or his appointed agent, the workpapers, as defined in W.S. 26-3-312;

(v) A representation that the accountant is properly licensed by an appropriate state licensing authority and is a member in good standing in the American Institute of Certified Public Accountants;

(vi) A representation that the accountant is in compliance with the requirements of W.S. 26-3-306.

26-3-312. Definition, availability and maintenance of independent certified public accountants' workpapers.

(a) Workpapers are the records kept by the independent certified public accountant of the procedures followed, the tests performed, the information obtained, and the conclusions reached pertinent to his audit of the financial statements of an insurer. Workpapers may include audit planning documentation, work programs, analyses, memoranda, letters of confirmation and representation, abstracts of company documents and schedules or commentaries prepared or obtained by the independent certified public accountant in the course of his audit of the financial statements of an insurer and which support his opinion of those financial statements.

(b) Every insurer required to file an audited financial report pursuant to this article shall require the accountant to make available for review by department examiners, all workpapers prepared in the conduct of his audit and any communications related to the audit between the accountant and the insurer, at the offices of the insurer, the department or at any other reasonable place designated by the commissioner. The insurer shall require that the accountant retain the audit workpapers and communications until the department has filed a report on examination covering the period of the audit but no longer than seven (7) years from the date of the audit report.

(c) In the conduct of the periodic review by the department examiners under this section, it shall be agreed that photocopies of pertinent audit workpapers may be made and retained by the department. Such reviews by the department examiners shall be considered investigations and all workpapers and communications obtained during the course of the investigations shall be afforded the same confidentiality as other examination workpapers generated by the department.

26-3-313. Exemptions and effective dates.

(a) Upon written application of any insurer, the commissioner may grant an exemption from compliance with any or all provisions of this article if the commissioner finds, upon review of the application, that compliance with this article would constitute a financial or organizational hardship upon the insurer. Exemptions may be granted at any time for a specified period. Within ten (10) days from a denial of an insurer's written request for an exemption from this article, the insurer may request in writing a hearing on its application for an exemption. The hearing shall be held in accordance with the rules and regulations of the department pertaining to administrative hearing procedures.

(b) Repealed by Laws 2009, Ch. 94, § 3.

(c) Repealed by Laws 2009, Ch. 94, § 3.

(d) The requirements of W.S. 26-3-316 are effective January 1, 2019. If an insurer or group of insurers who are exempt from the requirements of W.S. 26-3-316 no longer qualify for the exemption, the insurer or group of insurers shall have one (1) year after the year the threshold is exceeded in which to comply with the requirements of this article.

26-3-314. Canadian and British companies.

In the case of Canadian and British insurers, the annual audited financial report shall be defined as the annual statement of total business on the form filed by such companies with their supervision authority duly audited by an independent chartered accountant. For Canadian and British insurers, the letter required in W.S. 26-3-305(b) shall state that the accountant is aware of the requirements relating to the annual audited financial report filed with the commissioner pursuant to W.S. 26-3-303 and shall affirm that the opinion expressed is in conformity with those requirements.

26-3-315. Requirements for audit committees.

(a) An audit committee shall be directly responsible for the appointment, compensation and oversight of the work of any accountant, including resolution of disagreements between management and the accountant regarding financial reporting, employed for the purpose of preparing or issuing the audited financial report or related work pursuant to this article and each accountant shall report directly to the audit committee.

(b) The audit committee of an insurer or group of insurers shall be responsible for overseeing the insurer's internal audit function and granting the persons performing the function suitable authority and resources to fulfill their responsibilities if required by W.S. 26-3-316.

(c) Each member of the audit committee shall be a member of the board of directors of the insurer or a member of the board of directors of an entity elected pursuant to W.S. 26-3-302(a)(vi) and subsection (f) of this section.

(d) In order to be considered independent for purposes of this section, a member of the audit committee shall not, other than in his capacity as a member of the audit committee, the board of directors or any other board committee, accept any consulting, advisory or other compensatory fee from the entity or be an affiliated person of the entity or any subsidiary thereof. If any other provision of law requires board participation by otherwise nonindependent members, that law shall prevail and those members may participate in the audit committee and be designated as independent for audit committee purposes unless they are an officer or employee of the insurer or one (1) of its affiliates.

(e) If a member of the audit committee ceases to be independent for reasons outside the member's reasonable control, that person, with notice by the responsible entity to the state, may remain an audit committee member of the responsible entity until the earlier of the next annual meeting of the responsible entity or one (1) year from the occurrence of the event that caused the member to be no longer independent.

(f) To exercise the election of the controlling person to designate the audit committee for purposes of this article, the ultimate controlling person shall provide written notice to the commissioners of the affected insurers. Notification shall be made timely prior to the issuance of the statutory audit report and include a description of the basis for the election. The election may be changed through notice to the commissioner by the insurer which shall include a description of the basis for the change. The election shall remain in effect for perpetuity, until rescinded.

(g) The audit committee shall require the accountant that performs for an insurer any audit required by this article to timely report to the audit committee in accordance with the requirements of Statement on Auditing Standards 61, Communication with Audit Committees, or its replacement, including:

(i) All significant accounting policies and material permitted practices;

(ii) All material alternative treatments of financial information within statutory accounting principles that have been discussed with management officials of the insurer, ramifications of the use of the alternative disclosures and treatments and the treatment preferred by the accountant; and

(iii) Other material written communications between the accountant and the management of the insurer, such as any management letter or schedule of unadjusted differences.

(h) If an insurer is a member of an insurance holding company system, the reports required under subsection (g) of this section may be provided to the audit committee on an aggregate basis for insurers in the holding company system, provided that any substantial differences among insurers in the system are identified to the audit committee.

(j) The proportion of independent audit committee members shall meet or exceed the following criteria, except that the commissioner has authority afforded by state law to require the entity's board to enact improvements to the independence of the audit committee membership if the insurer is in any RBC action level event, meets one (1) or more of the standards of an insurer deemed to be in hazardous financial condition or otherwise exhibits qualities of a troubled insurer:

(i) For insurers with prior calendar year direct written and assumed premiums of five hundred million dollars ($500,000,000.00) or less the audit committee shall have a majority of members that are independent and the insurers are encouraged to structure their audit committees with at least seventy-five percent (75%) of the audit committee members being independent;

(ii) For insurers with prior calendar year direct written and assumed premiums of more than five hundred million dollars ($500,000,000.00) at least seventy-five percent (75%) of the members of the audit committee shall be independent;

(iii) For purposes of this subsection, prior calendar year direct written and assumed premiums shall be the combined total of direct premiums and assumed premiums from nonaffiliates for the reporting entities.

(k) An insurer with direct written and assumed premiums, excluding premiums reinsured with the federal crop insurance corporation and federal flood program, less than five hundred million dollars ($500,000,000.00) may make application to the commissioner for a waiver from the requirements of this section based on hardship. The insurer shall file, with its annual statement filing, the approval for relief from this section with the states that it is licensed in or doing business in and the National Association of Insurance Commissioners. If the nondomestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC.

(m) This section shall not apply to foreign or alien insurers licensed in this state or an insurer that is a SOX compliant entity or a direct or indirect wholly-owned subsidiary of a SOX compliant entity, as defined in W.S. 26-3-302(a)(xiii).

(n) An insurer or group of insurers that is not required to have independent audit committee members or only a majority

of independent audit committee members because the total written and assumed premium is below the threshold and subsequently becomes subject to any of the independence requirements due to changes in premiums shall have one (1) year following the year the threshold is exceeded to comply with the independence requirements. An insurer that becomes subject to any of the independence requirements as a result of a business combination shall have one (1) calendar year following the date of acquisition or combination to comply with the independence requirements.

26-3-316. Internal audit function requirements.

(a) An insurer is exempt from the requirements of this section if:

(i) The insurer has annual direct written and unaffiliated assumed premiums, including international direct and assumed premiums, but excluding premiums reinsured with the federal crop insurance corporation and federal flood program, less than five hundred million dollars ($500,000,000.00); and

(ii) If the insurer is a member of a group of insurers, the group has annual direct written and unaffiliated assumed premiums, including international direct and assumed premiums, but excluding premiums reinsured with the federal crop insurance corporation and federal flood program, less than one billion dollars ($1,000,000,000.00).

(b) Each insurer or group of insurers shall establish an internal audit function providing independent oversight regarding the insurer's governance, risk management and internal controls. This oversight shall be provided by performing general and specific audits, reviews and tests and by employing other techniques deemed necessary to protect assets, evaluate control effectiveness and efficiency and evaluate compliance with policies and regulations.

(c) The internal audit function shall be organizationally independent. Specifically, the internal audit function shall not defer ultimate judgment on audit matters to others and shall appoint an individual to head the internal audit function who shall have direct and unrestricted access to the board of directors. Organizational independence does not preclude dual reporting relationships.

(d) The head of the internal audit function shall report to the audit committee regularly, but not less than annually, on the periodic audit plan, factors that may adversely impact the internal audit function's independence or effectiveness, material findings from completed audits and the appropriateness of corrective actions implemented by management as a result of audit findings.

(e) If an insurer is a member of an insurance holding company system or included in a group of insurers, the insurer may satisfy the internal audit function requirements set forth in this section at the ultimate controlling parent level, an intermediate holding company level or the individual legal entity level.

26-3-317. Conduct of insurer in connection with preparation of required reports and documents.

(a) No director or officer of an insurer shall, directly or indirectly:

(i) Make or cause to be made a materially false or misleading statement to an accountant in connection with any audit, review or communication required under this article; or

(ii) Omit to state or cause another person to omit to state any material fact necessary in order to make statements made, in light of the circumstances under which the statements were made, not misleading to an accountant in connection with any audit, review or communication required under this article.

(b) No officer or director of an insurer or any other person acting under the direction thereof shall directly or indirectly take any action to coerce, manipulate, mislead or fraudulently influence any accountant engaged in the performance of an audit pursuant to this article if that person knew or should have known that the action, if successful, could result in rendering the insurer's financial statements materially misleading. For purposes of this subsection, actions that, if successful, could result in rendering the insurer's financial statements materially misleading include, but are not limited to, actions taken at any time with respect to the professional engagement period to coerce, manipulate, mislead or fraudulently influence an accountant to:

(i) Issue or reissue a report on an insurer's financial statements that is not warranted in the circumstances

due to material violations of statutory accounting principles prescribed by the commissioner, generally accepted auditing standards or other professional or regulatory standards;

(ii) Not perform any audit, review or other procedures required by generally accepted auditing standards or other professional standards;

(iii) Not withdraw an issued report; or

(iv) Not communicate matters to an insurer's audit committee.

(c) Violation of this section shall be punishable as provided in W.S. 26-1-107.

26-3-318. Management's report of internal control over financial reporting.

(a) Every insurer required to file an audited financial report pursuant to this article that has annual direct written and assumed premiums, excluding premiums reinsured with the federal crop insurance corporation and federal flood program, of five hundred million dollars ($500,000,000.00) or more shall prepare a report of the insurer's or group of insurers' internal control over financial reporting. The report shall be filed with the commissioner along with the communication of internal control related matters noted in an audit described in W.S. 26-3-310. Management's report of internal control over financial reporting shall be as of the immediately preceding December 31.

(b) Notwithstanding the premium threshold in subsection (a) of this section, the commissioner may require an insurer to file management's report of internal control over financial reporting if the insurer is in any RBC level event or meets any one (1) or more of the standards of an insurer deemed to be in hazardous financial condition as defined in W.S. 26-3-116.

(c) An insurer or group of insurers that is directly subject to section 404, part of a holding company system whose parent is directly subject to section 404, not directly subject to section 404 but is a SOX compliant entity or a member of a holding company system whose parent is not directly subject to section 404 but is a SOX compliant entity, may file its or its parent's section 404 report and an addendum in satisfaction of this section provided that those internal controls of the insurer or group of insurers having material impact on the

preparation of the insurer's or group of insurers' audited statutory financial statements were included in the scope of the section 404 report. The addendum shall be a positive statement by management that there are no material processes with respect to the preparation of the insurer's or group of insurers' audited financial statements excluded from the section 404 report. If there are internal controls of the insurer or group of insurers that have a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements and those internal controls were not included in the scope of the section 404 report, the insurer or group of insurers may either file a report under this section or the section 404 report and a report under this section for those internal controls that have a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements not covered by the section 404 report.

(d) A management's report of internal control over financial reporting shall include:

(i) A statement that management is responsible for establishing and maintaining adequate internal control over financial reporting;

(ii) A statement that management has established internal control over financial reporting and an assertion to the best of management's knowledge and belief, after diligent inquiry, as to whether its internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles;

(iii) A statement that briefly describes the approach or processes by which management evaluated the effectiveness of its internal control over financial reporting;

(iv) A statement that briefly describes the scope of work that is included and whether any internal controls were excluded;

(v) Disclosure of any unremediated material weaknesses in the internal control over financial reporting identified by management as of the immediately preceding December 31. Management shall not conclude that the internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles if

there is one (1) or more unremediated material weakness in its internal controls over financial reporting;

(vi) A statement regarding the inherent limitations of internal control systems; and

(vii) Signatures of the chief executive officer and the chief financial officer or the equivalent position.

(e) Management shall document and make available upon financial condition examination the basis upon which its assertions required in subsection (d) of this section are made. Management may base its assertions, in part, upon its review, monitoring and testing of internal controls undertaken in the normal course of its activities. Management shall have discretion as to the nature of the internal control framework used and the nature and extent of documentation in order to make its assertions in a cost effective manner and may include assembly of or reference to existing documentation. Management's report on internal control over financial reporting and any documentation provided in support thereof during the course of a financial conditions examination shall be kept confidential by the department.

(f) The requirements of this section are effective beginning with the reporting period ending December 31, 2010 and each year thereafter. An insurer or group of insurers that is not required to file a report because the total written premium is below the threshold and subsequently becomes subject to the reporting requirements shall have two (2) years following the year the threshold is exceeded to file a report. An insurer that becomes subject to any of the reporting requirements as a result of a business combination shall have two (2) calendar years following the date of acquisition or combination to comply with the reporting requirements.

ARTICLE 4 - DISCLOSURE OF MATERIAL TRANSACTIONS

26-3-401. Report of material transactions.

(a) Every insurer domiciled in this state, and effective July 1, 1996, every authorized foreign insurer not subject to a substantially similar provision in its domicile, shall file a report with the commissioner disclosing material acquisitions and dispositions of assets or material nonrenewals, cancellations or revisions of ceded reinsurance agreements unless the acquisitions and dispositions of assets or material

nonrenewals, cancellations or revisions of ceded reinsurance agreements have been submitted to the commissioner for review, approval or information purposes pursuant to other provisions of the insurance code, department regulations or other requirements.

(b) The report required in subsection (a) of this section is due within fifteen (15) days after the end of the calendar month in which any of the transactions occur.

(c) One (1) complete copy of the report, including any exhibits or other attachments filed as part of the report, shall be filed with:

(i) The department; and

(ii) The National Association of Insurance Commissioners.

(d) All reports obtained by or disclosed to the commissioner pursuant to this article shall be given confidential treatment, and shall not be made public by the commissioner, the National Association of Insurance Commissioners, or any other person, except:

(i) To persons as authorized by and in accordance with the provisions of W.S. 26-2-113(d);

(ii) Upon the prior written consent of the insurer to which it pertains; or

(iii) If the commissioner, after giving the insurer who would be affected, notice and an opportunity to be heard, determines the interest of policyholders, shareholders or the public will be served by publication of the report, the commissioner may publish all or any part of the report he deems appropriate.

26-3-402. Acquisitions and dispositions of assets.

(a) Subject to subsection (c) of this section, asset acquisitions subject to this article include every purchase, lease, exchange, merger, consolidation, succession or other acquisition other than the construction or development of real property by or for the reporting insurer or the acquisition of materials for such purpose.

(b) Subject to subsection (c) of this section, asset dispositions subject to this article include every sale, lease, exchange, merger, consolidation, mortgage, assignment for the benefit of creditors or otherwise, abandonment, destruction or other disposition.

(c) No acquisition or disposition of assets shall be reported pursuant to W.S. 26-3-401 if the acquisition or disposition is not material. A material acquisition, disposition or the aggregate of any series of related acquisitions or dispositions during any thirty (30) day period, is one which is:

(i) Nonrecurring;

(ii) Not in the ordinary course of business; and

(iii) Involves more than five percent (5%) of the reporting insurer's total admitted assets as reported in its most recent statutory statement filed with the insurance department of the insurer's state of domicile.

(d) The following information is required to be disclosed in any report of a material acquisition or disposition of assets:

(i) Date of the transaction;

(ii) Manner of acquisition or disposition;

(iii) Description of the assets involved;

(iv) Nature and amount of the consideration given or received;

(v) Purpose of, or reason for, the transaction;

(vi) Manner by which the amount of consideration was determined;

(vii) Gain or loss recognized or realized as a result of the transaction; and

(viii) Name of the person from whom the assets were acquired or to whom they were disposed.

(e) Insurers are required to report material acquisitions and dispositions on a nonconsolidated basis unless the insurer is part of a consolidated group of insurers which utilizes a pooling arrangement or one hundred percent (100%) reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer ceded substantially all of its direct and assumed business to the pool. An insurer is deemed to have ceded substantially all of its direct and assumed business to a pool if:

(i) The insurer has less than one million dollars ($1,000,000.00) total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement; and

(ii) The net income of the business not subject to the pooling arrangement represents less than five percent (5%) of the insurer's capital and surplus.

26-3-403. Nonrenewals, cancellations or revisions of ceded reinsurance agreements.

(a) No nonrenewal, cancellation or revision of ceded reinsurance agreements need be reported pursuant to W.S. 26-3-401 if the nonrenewal, cancellation or revision is not material. For purposes of this article, a material nonrenewal, cancellation or revision is one that affects for property and casualty business, including accident and health business when written as such, more than fifty percent (50%) of an insurer's ceded written premium, or for life, annuity and accident and health business, more than fifty percent (50%) of the total reserve credit taken for business ceded, on an annualized basis as indicated in the insurer's most recently filed statutory statement. No filing is required if the insurer's ceded written premium or the total reserve credit taken for business ceded represents, on an annualized basis, less than ten percent (10%) of direct plus assumed written premium or ten percent (10%) of the statutory reserve requirement prior to any cession, respectively.

(b) Subject to subsection (a) of this section, a report shall be filed without regard to which party has initiated the nonrenewal, cancellation or revision of ceded reinsurance whenever one (1) or more of the following conditions exist:

(i) The entire cession has been canceled, nonrenewed or revised and ceded indemnity and loss adjustment expense

reserves after any nonrenewal, cancellation or revision represent less than fifty percent (50%) of the comparable reserves that would have been ceded had the nonrenewal, cancellation or revision not occurred;

(ii) An authorized or accredited reinsurer has been replaced on an existing cession by an unauthorized reinsurer; or

(iii) Collateral requirements previously established for unauthorized reinsurers have been reduced, including, but not limited to, the requirement to collateralize incurred but not reported claim reserves being waived with respect to one (1) or more unauthorized reinsurers newly participating in an existing cession.

(c) Subject to subsection (a) of this section, for purposes of paragraphs (b)(ii) and (iii) of this section, a report shall be filed if the result of the revision affects more than ten percent (10%) of the cession.

(d) The following information is required to be disclosed in any report of a material nonrenewal, cancellation or revision of ceded reinsurance agreements:

(i) Effective date of the nonrenewal, cancellation or revision;

(ii) The description of the transaction with an identification of the initiator;

(iii) Purpose of, or reason for, the transaction; and

(iv) If applicable, the identity of the replacement reinsurers.

(e) Insurers are required to report all material nonrenewals, cancellations or revisions of ceded reinsurance agreements on a nonconsolidated basis unless the insurer is part of a consolidated group of insurers which utilizes a pooling arrangement or one hundred percent (100%) reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer ceded substantially all of its direct and assumed business to the pool. An insurer is deemed to have ceded substantially all of its direct and assumed business to a pool if the insurer has less than one million dollars ($1,000,000.00) total direct plus assumed written premiums during a calendar year which are not subject to a pooling

arrangement and the net income of the business not subject to the pooling arrangement represents less than five percent (5%) of the insurer's capital and surplus.

ARTICLE 5 - ELECTRONIC DELIVERY OF DOCUMENTS

26-3-501. Applicability.

(a) This article shall apply to property and casualty insurance, life insurance and disability insurance, including:

(i) Accident only insurance;

(ii) Accidental death or dismemberment insurance;

(iii) Credit insurance;

(iv) Dental or vision care insurance;

(v) Medicare supplemental insurance as defined by section 1882(g)(i) of the federal Social Security Act;

(vi) Long-term care insurance, including nursing home fixed indemnity insurance;

(vii) Disability income or a combination of accident only and disability income insurance;

(viii) Insurance issued as a supplement to liability insurance;

(ix) Specified disease insurance;

(x) Workers' compensation insurance;

(xi) Medical payment insurance coverage provided under a motor vehicle insurance policy;

(xii) Hospital confinement indemnity insurance;

(xiii) Limited benefit insurance that is offered and marketed as supplemental health insurance and not as a substitute for hospital or medical insurance or major medical expense insurance.

26-3-502. Electronic notices and documents.

(a) Subject to subsection (c) of this section, any notice to a party or any other document required under applicable law in an insurance transaction or that is to serve as evidence of insurance coverage may be delivered, stored and presented by electronic means so long as it meets the requirements of the Uniform Electronic Transactions Act, W.S. 40-21-101 through 40-21-119.

(b) Delivery of a notice or document in accordance with this section shall be considered equivalent to any delivery method required under applicable law including chapter 35 of this code, including delivery by first class mail, first class mail postage prepaid, certified mail, certificate of mail or certificate of mailing.

(c) A notice or document may be delivered by electronic means by an insurer to a party under this section if all of the following are met:

(i) The party has affirmatively consented to that method of delivery and has not withdrawn the consent;

(ii) The party, before giving consent, is provided with a clear and conspicuous statement informing the party of:

(A) Any right or option of the party to have the notice or document provided or made available in paper or another nonelectronic form;

(B) The right of the party to withdraw consent to have a notice or document delivered by electronic means and any fees, conditions or consequences imposed in the event consent is withdrawn;

(C) Whether the party's consent applies:

(I) Only to the particular transaction as to which the notice or document must be given; or

(II) To identified categories of notices or documents that may be delivered by electronic means during the course of the parties' relationship.

(D) The means, after consent is given, by which a party may obtain a paper copy of a notice or document delivered by electronic means and the fee, if any, for the paper copy; and

(E) The procedure a party must follow to withdraw consent to have a notice or document delivered by electronic means and to update information needed to contact the party electronically.

(iii) The party:

(A) Before giving consent, is provided with a statement of the hardware and software requirements for access to and retention of a notice or document delivered by electronic means; and

(B) Consents electronically, or confirms consent electronically, in a manner that reasonably demonstrates that the party can access information in the electronic form that will be used for notices or documents delivered by electronic means as to which the party has given consent.

(iv) After consent of the party is given, the insurer, in the event a change in the hardware or software requirements needed to access or retain a notice or document delivered by electronic means creates a material risk that the party will not be able to access or retain a subsequent notice or document to which the consent applies:

(A) Delivery to an electronic mail address at which a party has consented to receive notices or documents; or

(B) Posting on an electronic network or site accessible via the internet, mobile application, computer, mobile device, tablet or any other electronic device, together with separate notice of the posting which shall be provided by electronic mail to the address at which the party has consented to receive notice or by any other delivery method that has been consented to by the party.

(I) The revised hardware and software requirements for access to and retention of a notice or document delivered by electronic means;

(II) The right of the party to withdraw consent without the imposition of any fee, condition, or consequence that was not disclosed under subparagraph (ii)(B) of this subsection.

(d) This section does not affect requirements related to content or timing of any notice or document required under applicable law.

(e) If a provision of this title or applicable law requiring a notice or document to be provided to a party expressly requires verification or acknowledgment of receipt of the notice or document, the notice or document may be delivered by electronic means only if the method used provides for verification or acknowledgment of receipt.

(f) The legal effectiveness, validity or enforceability of any contract or policy of insurance executed by a party may not be denied solely because of the failure to obtain electronic consent or confirmation of consent of the party in accordance with subparagraph (c)(iii)(B) of this section.

(g) With respect to withdrawal of consent, the following apply:

(i) A withdrawal of consent by a party does not affect the legal effectiveness, validity or enforceability of a notice or document delivered by electronic means to the party before the withdrawal of consent is effective;

(ii) A withdrawal of consent by a party is effective within a reasonable period of time after receipt of the withdrawal by the insurer;

(iii) Failure by an insurer to comply with paragraph (c)(iv) of this section may be treated, at the election of the party, as a withdrawal of consent for purposes of this section.

(h) This section does not apply to a notice or document delivered by an insurer in an electronic form before July 1, 2014 to a party who, before that date, has consented to receive notice or document in an electronic form otherwise allowed by law.

(j) If the consent of a party to receive certain notices or documents in an electronic form is on file with an insurer before July 1, 2014, and pursuant to this section, an insurer intends to deliver additional notices or documents to such party in an electronic form, then prior to delivering such additional notices or documents electronically, the insurer shall notify the party of:

(i) The notices or documents that may be delivered by electronic means under this section that were not previously delivered electronically; and

(ii) The party's right to withdraw consent to have notices or documents delivered by electronic means.

(k) Except as otherwise provided by law, if an oral communication or a recording of an oral communication from a party can be reliably stored and reproduced by an insurer, the oral communication or recording may qualify as a notice or document delivered by electronic means for purposes of this section. If a provision of this title or applicable law requires a signature or notice or document to be notarized, acknowledged, verified or made under oath, the requirement is satisfied if the electronic signature of the person authorized to perform those acts, together with all other information required to be included by the provision, is attached to or logically associated with the signature, notice or document.

(m) This section may not be construed to modify, limit or supersede the provisions of the federal Electronic Signatures in Global and National Commerce Act, Public Law 106-229, as amended.

(n) As used in this section:

(i) "Delivered by electronic means" includes:

(A) Delivery to an electronic mail address at which a party has consented to receive notices or documents; or

(B) Posting on an electronic network or site accessible via the internet, mobile application, computer, mobile device, tablet or any other electronic device, together with separate notice of the posting which shall be provided by electronic mail to the address at which the party has consented to receive notice or by any other delivery method that has been consented to by the party.

(ii) "Party" means any recipient of any notice or document required as part of an insurance transaction, including but not limited to an applicant, an insured, a policyholder or an annuity contract holder.

26-3-503. Posting of policies on the internet.

(a) Notwithstanding any other provisions of W.S. 26-3-502, standard insurance policies and endorsements to which this article is applicable that do not contain personally identifiable information may be mailed, delivered or posted on the insurer's web site. If the insurer elects to post insurance policies and endorsements on its web site in lieu of mailing or delivering them to the insured, it shall comply with all of the following conditions:

(i) The policy and endorsements shall be accessible and remain that way for as long as the policy is in force;

(ii) After the expiration of the policy, the insurer shall archive its expired policies and endorsements for a period of ten (10) years, and make them available upon request;

(iii) The policies and endorsements shall be posted in a manner that enables the insured to print and save the policy and endorsements using programs or applications that are widely available on the internet and free to use;

(iv) The insurer provides the following information in, or simultaneous with each declarations page provided at the time of issuance of the initial policy and any renewals of that policy:

(A) A description of the exact policy and endorsement forms purchased by the insured;

(B) A method by which the insured may obtain, upon request and without charge, a paper copy of their policy;

(C) The internet address where their policy and endorsements are posted.

(v) The insurer provides notice, in the format preferred by the insured, of any changes to the forms or endorsements, the insured's right to obtain, upon request and without charge, a paper copy of such forms or endorsements, and the internet address where such forms or endorsements are posted.

CHAPTER 4 - FEES AND TAXES

26-4-101. Fee schedule.

(a) The commissioner shall collect in advance or contemporaneously fees, licenses and miscellaneous charges as specified in this subsection. Collection may include the acceptance of electronic funds transfer. All fees and other charges collected by the commissioner as specified in this subsection shall be nonrefundable:

(i) Certificate of authority:

(A) For filing application for insurer's initial certificate of authority, excluding multiple employer welfare arrangements, including all documents submitted as a part of the application, examination of application and issuance of certificate of authority, if issued $750.00

(B) Annual continuation, excluding multiple employer welfare arrangements, including filing of annual statement $500.00

(C) Reinstatement (W.S. 26-3-114(c)) $ 50.00

(D) Certified copy $15.00

(E) Registration of additional title (W.S. 26-3-120) $ 25.00

Annual renewal $ 25.00

(ii) Charter documents (other than those filed with application for certificate of authority). Filing amendments to articles of incorporation, charter, bylaws, power of attorney (as to reciprocal insurers) and other constituent documents of the insurer, each document

....$ 10.00

(iii) Annual statement. For filing annual statement other than included with (a)(i)(A) or (B) of this subsection $ 25.00

(iv) Service of process, acceptance $ 10.00

(v) Insurance producers or title agents:

(A) Property, casualty, personal lines or title:

(I) Application for original resident license and issuance of license, if issued $100.00

(II) Appointment, each producer or agent, each insurer $15.00

(III) Annual continuation of appointment, each insurer $15.00

(IV) Temporary license, application fee, and issuance, if issued $ 10.00

(V) License under waiver of residency requirement pursuant to a reciprocal agreement, application fee and issuance $150.00

(VI) Continuation of license:

Resident $100.00

Nonresident $150.00

(VII) Statement of termination of appointment, each insurer $15.00

(B) Life, accident and health or sickness or disability, variable life and variable annuities or credit:

(I) Application for original resident license and issuance of license, if issued $100.00

(II) Appointment, each producer oragent, each insurer $15.00

(III) Annual continuation of appointment, each insurer $15.00

(IV) Temporary license, application fee, and issuance, if issued $ 10.00

(V) License under waiver of residency requirement pursuant to a reciprocal agreement, application fee and issuance $150.00

(VI) Continuation of license:

Resident $100.00

Nonresident $150.00

(VII) Statement of termination of appointment, each insurer $15.00

(vi) Repealed By Laws 2004, Chapter 7, § 2.

(vii) Repealed by Laws 2001, Ch. 201, § 5.

(viii) Surplus line brokers:

Application for original resident license, and issuance of license, if issued $100.00

License under waiver of residency requirement pursuant to a reciprocal agreement, application fee and issuance $150.00

Continuation of license:

Resident $100.00

Nonresident $150.00

(ix) Adjusters:

Application for original resident license, and issuance of license, if issued $100.00

License under waiver of residency requirement pursuant to a reciprocal agreement, application fee and issuance $150.00

Continuation of license:

Resident $100.00

Nonresident $150.00

(x) Repealed By Laws 2004, Chapter 7, § 2.

(xi) Repealed By Laws 2011, Ch. 60, § 3.

(xii) Insurance consultant for hire:

Application for original resident license, and issuance, if issued $100.00

License under waiver of residency requirement pursuant to a reciprocal agreement, application fee and issuance $150.00

Continuation of license:

Resident $100.00

Nonresident $150.00

(xiii) Repealed by Laws 1993, ch. 97, § 2.

(xiv) Limited lines producers:

Application for original individual license and issuance of license, if issued $20.00

Continuation of individual license $20.00

Application for original business entity license and issuance of license, if issued $100.00

Continuation of business entity license $100.00

(xv) Rating organization license or triennial renewal thereof, including all kinds of insurance as to which licensed $150.00

(xvi) Certification of any document and affixing seal of office thereto $ 15.00

(xvii) Copies of documents on file in the department, a reasonable uniform charge per page as fixed by the commissioner;

(xviii) Pharmacy benefit manager (annually) $500.00

(xix) Third party administrator (biennial) ..... $ 200.00

(xx) Multiple employer welfare arrangement, annual license or renewal $500.00.

(xxi) Continuing education:

Application for approval of continuing education provider

$100.00

Continuation of continuing education provider approval

$100.00

Application for course approval $50.00

Continuation of course approval $50.00

(b) Repealed by Laws 1993, ch. 97, § 2.

26-4-102. Record of receipts; payment to treasurer; credit to fund.

(a) The commissioner shall keep a complete and accurate record of all monies he receives and disburses. All tax returns and records are open to examination at any time by the director of the state department of audit or his representative.

(b) The commissioner shall promptly deposit all monies he receives from any charges to the general fund, with receipt and acknowledgement submitted to the state treasurer, except that:

(i) Repealed by Laws 2017, ch. 9, § 3.

(ii) The gross premium tax levied upon fire insurance premiums shall be deposited by the state treasurer as provided in this paragraph. For purposes of this paragraph, the gross premium tax levied upon fire insurance premiums is equal to thirty percent (30%) of the total gross premium tax levied upon all property, casualty and multiple line insurers. The gross premium tax levied upon fire insurance premiums shall be deposited as follows:

(A) Up to one hundred percent (100%) of the gross premium tax, less any amount deposited under subparagraph (B) of this paragraph, shall be deposited by the state treasurer in the volunteer firefighter, EMT and search and rescue pension account pursuant to W.S. 35-9-628;

(B) Forty percent (40%) of the gross premium tax shall be deposited by the state treasurer in the Fire A legislative reserve account created by W.S. 15-5-202(e), provided that no deposit shall be made under this subparagraph on and after the date that the firemen plan A as defined in W.S. 15-5-211(a)(i) has no remaining members receiving benefits.

(iii) Any premium assessments collected under W.S. 26-4-103(n), which shall be transferred to the air ambulance coverage account not more than thirty (30) days after receipt.

26-4-103. Premium taxes; generally; preemption by state.

(a) Each authorized and formerly authorized insurer shall file with the commissioner on or before March 1 each year or within any extended period the commissioner grants not to exceed thirty (30) days, a report in a form the commissioner prescribes showing, except for wet marine and transportation insurance as defined in W.S. 26-5-107 and except as provided under subsection (k) of this section, total direct premium income including policy, membership and other fees, and all other considerations for insurance and annuity contracts, however designated, it received during the immediately preceding calendar year because of policies and contracts covering property, subjects or risks located, resident or to be performed in this state. The report shall also identify separately the premiums charged on life insurance policies with annualized premiums exceeding one hundred thousand dollars ($100,000.00) for the immediately preceding calendar year. The total direct premium income reported shall include proper proportionate allocation of premiums or consideration as to those persons, property, subjects or risks in this state insured or covered under policies or contracts covering persons, property, subjects or risks located or resident in more than one (1) state, and shall be computed after deducting:

(i) The amount of return premiums on cancelled policies, but not including the return of cash surrender values on life policies or annuity contracts; and

(ii) The amount returned to policyholders as current dividends.

(iii) Repealed by Laws 1986, ch. 22, §§ 1, 4.

(b) At the same time the report is filed, each insurer shall pay for the privilege of transacting business in this state, a tax upon net premiums and net considerations to be computed at the following rates:

(i) As to each insurer, the tax rate, except as to annuity considerations, shall be as follows:

(A) Repealed by Laws 2020, ch. 136, § 2.

(B) Repealed by Laws 2020, ch. 136, § 2.

(C) Repealed by Laws 2020, ch. 136, § 2.

(D) Except as provided in subparagraph (E) of this paragraph, for premium income received, seventy-five hundredths percent (.75%);

(E) For premium income received, seventy-five hundredths percent (.75%) on the first one hundred thousand dollars ($100,000.00) of a life insurance policy's annual premium and seventy-five thousandths of one percent (.075%) on that portion of a life insurance policy's annual premium exceeding one hundred thousand dollars ($100,000.00).

(ii) Repealed by Laws 1986, ch. 22, §§ 2, 4.

(iii) As to annuity considerations, the tax rate is one percent (1%).

(c) As to wet marine and transportation insurance, on or before March 1 of each year each authorized and formerly authorized insurer shall file its report with the commissioner, on forms he prescribes and furnishes or accepts, of its gross underwriting profit on that insurance written in Wyoming during the immediately preceding calendar year, and, at the same time, shall pay a tax of three-fourths percent (3/4%) of the gross underwriting profit.

(d) The gross underwriting profit shall be ascertained by deducting from the net premiums (i.e. gross premiums less all return premiums and premiums for reinsurance) on the wet marine and transportation insurance contracts the net losses paid (i.e. gross losses paid less salvage and recoveries on reinsurance ceded) during the calendar year under the contracts. In the case of insurers issuing participating contracts, for tax computation under this subsection, gross underwriting profit does not include the amounts refunded or paid as participating dividends by those insurers to the holders of those contracts.

(e) Repealed by Laws 1986, ch. 22, § 3.

(f) Payment of the tax required by this section is instead of all taxes imposed by the state upon premiums or upon income

and of franchise, privilege or other taxes measured by the insurer's income.

(g) The state preempts the field of regulating, or of imposing any taxes, licenses and fees upon insurers and their general agents, agents and other representatives and on the intangible property of insurers or their representatives. All political subdivisions or agencies in the state are prohibited from regulating insurers or their general agents, agents and other representatives and from imposing or levying upon them any tax, license or fee. This provision does not prohibit the imposition by political subdivisions of taxes upon real and tangible personal property of insurers, general agents, agents and representatives.

(h) The provisions of subsections (f) and (g) of this section shall not be modified or repealed by any law of general application enacted after December 31, 1967 unless expressly referred to or expressly repealed therein.

(j) No tax is due or payable because of premiums or considerations received from policies or contracts issued in connection with a pension annuity or profit-sharing plan exempt or qualified under sections 401, 403, 404, 408, 457 or 501 of the United States Internal Revenue Code of 1954, as amended or renumbered.

(k) Notwithstanding subsection (a) of this section, any authorized insurer selling insurance shall beginning January 1, 1991 and in accordance with this subsection, pay premium taxes quarterly based upon an estimate of taxes payable on total direct premium income including policy, membership and other fees:

(i) Each estimated quarterly tax payment shall be payable on or before the last day of the month immediately following the end of the calendar quarter for which payment is due, except payment for the calendar quarter ending December 31 of each year shall be payable on or before March 1 of the immediately succeeding calendar year and shall include any adjustments for the calendar year for which the final quarterly payment is made. Except for the calendar quarter ending December 31, the quarterly payment shall not be less than twenty-five percent (25%) of the total premium tax paid during the preceding calendar year;

(ii) Any adjustment to estimated quarterly payments for any calendar year and any claim by an insurer for a refund shall be made at the time of filing the annual report required under subsection (a) of this section. Following notice to the insurer by the commissioner, adjustment under this paragraph may be added to or deducted from subsequent quarterly payments under this subsection;

(iii) The commissioner shall suspend or revoke the certificate of authority for any insurer failing to pay premium taxes pursuant to this subsection.

(m) The amount of tax credits for which an insurer qualifies under W.S. 9-12-1301 through 9-12-1312 shall be allowed as a credit against premium tax owed by the insurer under subsections (a) through (k) of this section.

(n) At the same time a report under subsection (a) of this section is filed, an insurer making private health benefit plans available in this state, and any plan which has entered into agreement under W.S. 42-4-123(j), shall pay to the commissioner a three-quarter percent (.75%) assessment upon net premiums and net considerations. The commissioner shall, not more than thirty (30) days after receipt, transfer premium assessments paid under this subsection to the air ambulance coverage account. Application of this subsection shall be contingent on operation of the air ambulance transport services program under W.S. 42-4-123(b).

26-4-104. Repealed by Laws 1991, ch. 149, §§ 2(a) and (b).

26-4-105. Premium taxes; commissioner to collect tax; failure to pay.

(a) The taxes imposed under W.S. 26-4-103 shall be collected by the commissioner.

(b) If the insurer does not pay the tax on or before March 31 of the year in which due, the tax is delinquent, and the commissioner may enforce payment thereof by the seizure, distraint and sale of any of the insurer's property within Wyoming or by any other lawful means. If the tax is delinquent, the commissioner shall suspend or revoke the insurer's certificate of authority.

26-5-101. Definitions not mutually exclusive.

It is intended that certain insurance coverages may come within the definitions of two (2) or more kinds of insurance in this chapter, and the inclusion of a coverage within one (1) definition does not preclude it from being included within another definition in which it can be reasonably included.

26-5-102. "Life insurance" defined.

(a) Life insurance is insurance on human lives and the transaction of life insurance includes also the granting of:

(i) Endowment benefits;

(ii) Additional benefits because of death or dismemberment by accident or accidental means;

(iii) Additional benefits because of the insured's disability; and

(iv) Optional modes of settlement of proceeds of life insurance.

26-5-103. "Disability insurance" defined.

(a) Disability insurance is insurance of any kind on human beings against:

(i) Bodily injury, disablement or death by accident or accidental means, or the expense thereof; or

(ii) Disablement or expense resulting from sickness.

(b) For any statute with an effective date on or after July 2, 2011, and unless expressly and specifically provided by statute, the term "disability insurance" does not include any of the following excepted benefits:

(i) Accident only insurance;

(ii) Accidental death or dismemberment insurance;

(iii) Credit insurance;

(iv) Dental or vision care insurance;

(v) Medicare supplemental insurance as defined by section 1882(g)(i) of the federal Social Security Act;

(vi) Long-term care insurance, including nursing home fixed indemnity insurance, except if the commissioner determines that the insurance provides benefits so comprehensive that it is the equivalent of a health benefit plan and should not be exempt under this section;

(vii) Disability income or a combination of accident only and disability income insurance;

(viii) Insurance issued as a supplement to liability insurance;

(ix) Specified disease insurance;

(x) Workers' compensation insurance;

(xi) Medical payment insurance coverage provided under a motor vehicle insurance policy;

(xii) Hospital confinement indemnity insurance;

(xiii) Limited benefit insurance that is offered and marketed as supplemental health insurance and not as a substitute for hospital or medical insurance or major medical expense insurance.

26-5-104. "Property insurance" defined.

Property insurance is insurance on any property against loss or damage from any cause, and against loss consequential upon that loss or damage, other than noncontractual legal liability for that loss or damage. Property insurance does not include title insurance, as defined in W.S. 26-5-109.

26-5-105. "Surety insurance" defined.

(a) Surety insurance includes:

(i) Fidelity insurance, which is insurance guaranteeing the fidelity of persons holding positions of public or private trust;

(ii) Insurance guaranteeing the performance of contracts, other than insurance policies, and guaranteeing and executing bonds, undertakings and contracts of suretyship;

(iii) Insurance indemnifying insureds against:

(A) Loss, resulting from any cause, on bills of exchange, bonds, securities, deeds, warehouse receipts or other valuable papers, documents, money, precious metals and articles made therefrom, jewelry, watches, gems, precious and semiprecious stones, including any loss thereof while being transported in armored motor vehicles, or by messenger, but not including any other risks of transportation or navigation; or

(B) Loss or damage to an insured's premises or to his furnishings, fixtures, equipment, safes and vaults therein, caused by actual or attempted burglary, robbery, theft, vandalism or malicious mischief.

26-5-106. "Casualty insurance" defined.

(a) Casualty insurance includes:

(i) Insurance against:

(A) Loss of or damage to any land vehicle or aircraft or any draft or riding animal or to property while contained therein or thereon or being loaded or unloaded therein or therefrom, from any cause;

(B) Any loss, liability or expense resulting from or incidental to ownership, maintenance or use of any vehicle, aircraft or animal; and

(C) Accidental injury to individuals, regardless of legal liability of the insured, including the named insured, while in, entering, alighting from, adjusting, repairing, cranking or caused by being struck by a vehicle, aircraft or draft or riding animal, if the insurance is issued as an incidental part of insurance on the vehicle, aircraft or draft or riding animal.

(ii) Insurance against legal liability for the death, injury, or disability of any human being or for damage to property, and provision of medical, hospital, surgical and disability benefits to injured persons and funeral and death benefits to dependents, beneficiaries or personal

representatives of persons killed, regardless of legal liability of the insured, if issued as an incidental coverage with or supplemental to liability insurance;

(iii) Insurance of the obligations accepted by, imposed upon or assumed by employers under law for death, disablement or injury of employees;

(iv) Insurance against loss or damage:

(A) By actual or attempted burglary, theft, robbery, forgery, fraud, vandalism, malicious mischief, confiscation, wrongful conversion, disposal or concealment, including supplemental coverage for medical, hospital, surgical and funeral expense incurred by the named insured or any other person as a result of bodily injury during the commission of a burglary, robbery or theft by another;

(B) To monies, coins, bullion, securities, notes, drafts, acceptances or any other valuable papers and documents from any cause.

(v) Insurance upon personal effects against loss or damage from any cause;

(vi) Insurance against loss or damage to glass, including its lettering, ornamentation and fittings;

(vii) Insurance against any liability and loss or damage to property or interest resulting from accidents to or explosions of boilers, pipes, pressure containers, machinery or apparatus, and the inspection of and issuance of certificates of inspection upon boilers, machinery and apparatus of any kind, whether or not insured;

(viii) Insurance against loss or damage to:

(A) Any property or interest caused by the breakage or leakage of sprinklers, hoses, pumps and other fire extinguishing equipment or apparatus, water pipes or containers, or by water entering through leaks or openings in buildings; and

(B) The sprinklers, hoses, pumps and other fire extinguishing equipment or apparatus.

(ix) Insurance indemnifying the insured against loss or damage resulting from failure of debtors to pay their

obligations to the insured, including insurance to guarantee the repayment of real estate mortgages;

(x) Insurance against:

(A) Legal liability of the insured; and

(B) Loss, damage, or expense incidental to a claim of that liability, including medical, hospital, surgical and funeral benefits to injured persons, regardless of legal liability of the insured, because of death, injury or disablement of any person or damage to the economic interests of any person as the result of negligence in rendering expert, fiduciary or professional service.

(xi) Insurance against loss of or damage to any property of the insured, resulting from the ownership, maintenance or use of elevators, except loss or damage by fire and including the inspection of and issuance of certificates of inspection upon elevators;

(xii) Insurance against congenital defects in human beings;

(xiii) Insurance against loss or damage to livestock and services of a veterinary for those animals;

(xiv) Insurance indemnifying the producer of any motion picture, television, radio, theatrical, sport, spectacle, entertainment or similar production, event or exhibition against loss from interruption, postponement or cancellation thereof because of death, accidental injury or sickness of performers, participants, directors or other principals;

(xv) Insurance against any other kind of loss, damage or liability properly a subject of insurance and not within any other kind of insurance as defined in this chapter, if the commissioner does not disapprove the insurance as being contrary to law or public policy.

(b) Provision of medical, hospital, surgical and funeral benefits, and of coverage against accidental death or injury, as incidental to and part of other insurance as stated under paragraphs (a)(i), (ii), (iv), (vii), (x) and (xi) of this section is for all purposes the same kind of insurance to which it is so incidental and is not subject to provisions of this code applicable to life or disability insurances.

26-5-107. "Marine and transportation insurance" and "wet marine and transportation insurance" defined.

(a) "Marine and transportation insurance" includes:

(i) Insurance against any kinds of loss or damage to:

(A) Vessels, craft, aircraft vehicles of any kind, all cargoes, effects, disbursements, profits, monies, bullion, precious stones, securities, choses in action, evidences of debt, valuable papers, bottomry and respondentia interests and all other kinds of property and interests therein, incident thereto or in connection with any risks of any type of navigation, transit or transportation, or while being assembled or prepared in any manner for or awaiting shipment or during any delays, storage, transshipment or reshipment incident thereto, including marine builder's risks and all personal property, floater risks; and

(B) Person or to property in connection with or appertaining to a marine, inland marine, transit or transportation insurance, including liability for loss of or damage to either because of or in connection with the construction, repair, operation, maintenance or use of the subject matter of the insurance, excluding life insurance, surety bonds and insurance against loss by reason of bodily injury to the person because of the ownership, maintenance or use of automobiles; and

(C) Any jewels or precious metals used in any manner and whether in transportation or otherwise; and

(D) Bridges, tunnels and other instrumentalities of transportation, excluding buildings, their furnishings and fixed contents and supplies held in storage, unless fire, tornado, sprinkler leakage, hail, explosion, earthquake, riot or civil commotion or both, are the only hazards to be covered, piers, wharves, docks and slips, excluding the risks of fire, tornado, sprinkler leakage, hail, explosion, earthquake, riot or civil commotion or both, and other aids to navigation and transportation including dry docks and marine railways, against all risks; and

(ii) "Marine protection and indemnity insurance", meaning insurance against the insured or against legal liability of the insured for, loss, damage or expense arising out of or

incident to the ownership, operation, chartering, maintenance, use, repair or construction of any vessel or craft in use in ocean or inland waterways, including liability of the insured for personal injury, illness or death or for the loss of or damage to the property of another person.

(b) For the purposes of this code, "wet marine and transportation" insurance is that part of "marine and transportation" insurance which includes only:

(i) Insurance upon vessels, crafts, hulls and of interests therein or with relation thereto;

(ii) Insurance of marine builders' risks, marine war risks and contracts of marine protection and indemnity insurance;

(iii) Insurance of freights and disbursements pertaining to a subject of insurance coming within this definition; and

(iv) Insurance of personal property and interests therein in course of exportation from or importation into any country, or in course of transportation coastwise or on inland waters, including any form of transportation from point of origin to final destination in respect to or in connection with any risks of navigation, transit or transportation, and while being prepared for or awaiting shipment, and during any delays, storage, transshipment or reshipment incident thereto.

26-5-108. What insurance multiple line insurer may transact.

A multiple line insurer may transact any kind of insurance defined in this chapter, other than title insurance and, except as provided in W.S. 26-3-107(a)(i), life insurance or the granting of annuities.

26-5-109. "Title insurance" defined.

Title insurance is insurance of owners of property or others having an interest therein, or liens or encumbrances thereon, against loss by encumbrance, defective titles, invalidity or adverse claim to title.

26-5-110. Limit of risk.

(a) No insurer, other than a title insurer, shall retain any risk on any one (1) subject of insurance, regardless of where located or to be performed, in an amount exceeding ten percent (10%) of its surplus to policyholders.

(b) A "subject of insurance" for the purposes of this section, as to insurance against fire and hazards other than windstorm, earthquake and other catastrophic hazards, includes all properties insured by the same insurer which are customarily considered by underwriters to be subject to loss or damage from the same fire or the same occurrence of any other hazard insured against.

(c) Reinsurance ceded as authorized by W.S. 26-5-111 shall be deducted in determining risk retained. As to surety risks, the amount assumed by any established incorporated cosurety and the value of any security deposited, pledged or held subject to the surety's consent and for the surety's protection shall also be deducted.

(d) As to alien insurers, this section relates only to risks and surplus to policyholders of the insurer's United States branch.

(e) "Surplus to policyholders" for the purposes of this section, in addition to the insurer's capital and surplus, includes any voluntary reserves which are not required pursuant to law and shall be determined from the insurer's last sworn statement on file with the commissioner, or by the last report of examination of the insurer, whichever is the more recent at time of assumption of risk.

(f) This section does not apply to life or disability insurance, annuities, insurance of wet marine and transportation risks, worker's compensation insurance, employers' liability coverages nor to any policy or type of coverage as to which the maximum possible loss to the insurer is not readily ascertainable on issuance of the policy.

(g) Limits of risk as to newly formed domestic mutual insurers shall be as provided in W.S. 26-24-109.

26-5-111. Reinsurance.

(a) Repealed by Laws 1991, ch. 128, § 2.

(b) Repealed by Laws 1991, ch. 128, § 2.

(c) Repealed by Laws 1991, ch. 128, § 2.

(d) Repealed by Laws 1991, ch. 128, § 2.

(e) Repealed by Laws 1991, ch. 128, § 2.

(f) An insurer may accept reinsurance only on the risks and within the limits authorized.

(g) Repealed by Laws 1992, ch. 59, § 3.

(h) Repealed by Laws 1992, ch. 59, § 3.

(j) Repealed by Laws 1992, ch. 59, § 3.

(k) Repealed by Laws 1992, ch. 59, § 3.

(m) Repealed by Laws 1992, ch. 59, § 3.

(n) Repealed by Laws 1992, ch. 59, § 3.

26-5-112. Credit allowed a domestic ceding insurer.

(a) Except as provided in W.S. 26-5-113, and in addition to any rules adopted by the commissioner pursuant to W.S. 26-5-116 relating to the valuation of assets or reserve credits, the amount and forms of security supporting reinsurance arrangements and the circumstances pursuant to which credit will be reduced or eliminated, credit for reinsurance shall be allowed a domestic ceding insurer as either an asset or a deduction from liability on account of reinsurance ceded only if the reinsurer meets the requirements of any one (1) of the following paragraphs:

(i) The reinsurance is ceded to an assuming insurer which is licensed to transact insurance in this state;

(ii) The reinsurance is ceded to an assuming insurer which is accredited as a reinsurer in this state and whose accreditation has not been revoked by the commissioner. An accredited reinsurer is one which:

(A) Files with the commissioner evidence of its submission to this state's jurisdiction;

(B) Submits to this state's authority to examine its books and records;

(C) Is licensed to transact insurance or reinsurance in at least one (1) state, or in the case of a United States branch of an alien assuming insurer is entered through and licensed to transact insurance or reinsurance in at least one (1) state;

(D) Files annually with the commissioner a copy of its annual statement filed with the insurance department of its state of domicile and a copy of its most recent audited financial statement; and

(I) Repealed by Laws 2017, ch. 29, § 2.

(II) Repealed by Laws 2017, ch. 29, § 2.

(E) Demonstrates to the satisfaction of the commissioner that it has adequate financial capacity to meet its reinsurance obligations and is otherwise qualified to assume reinsurance from domestic insurers. An assuming insurer is deemed to meet this requirement as of the time of its application if it maintains a surplus as regards policyholders in an amount not less than twenty million dollars ($20,000,000.00) and its accreditation has not been denied by the commissioner within ninety (90) days after submission of its application.

(iii) The reinsurance is ceded to an assuming insurer which is domiciled and licensed in, or in the case of a United States branch of an alien assuming insurer is entered through and licensed in, a state which employs standards regarding credit for reinsurance which meet or exceed those applicable under this section and the assuming insurer or United States branch of an alien assuming insurer:

(A) Maintains a surplus as regards policyholders in an amount not less than twenty million dollars ($20,000,000.00), provided however that this requirement does not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system; and

(B) Submits to the authority of this state to examine its books and records.

(iv) The reinsurance is ceded to an assuming insurer not meeting the requirements of paragraphs (i) through (iii) or (v) through (vii) of this subsection but only with respect to the insurance of risks located in jurisdictions where such reinsurance is required by applicable law or regulation of that jurisdiction;

(v) The reinsurance is ceded to an assuming insurer which maintains a trust fund in a qualified United States financial institution, as defined in W.S. 26-5-114(b), for the payment of the valid claims of its United States policyholders and ceding insurers, their assigns and successors in interest. The assuming insurer shall report annually to the commissioner information substantially the same as that required to be reported on the NAIC annual statement form by licensed insurers to enable the commissioner to determine the sufficiency of the trust fund. The assuming insurer shall submit to examination of its books and records by the commissioner and bear the expense of examination. In the case of:

(A) A single assuming insurer, the trust shall consist of a trusteed account representing the assuming insurer's liabilities attributable to business written in the United States and, in addition, the assuming insurer shall maintain a trusteed surplus of not less than twenty million dollars ($20,000,000.00). At any time after the assuming insurer has permanently discontinued underwriting new business secured by the trust for at least three (3) years, the commissioner with principal regulatory oversight of the trust may authorize a reduction in the required trusteed surplus, but only after a finding, based on an assessment of the risk, that the new required surplus level is adequate for the protection of United States ceding insurers, policyholders and claimants in light of reasonably foreseeable adverse loss development. The risk assessment may involve an actuarial review, including an independent analysis of reserves and cash flows, and shall consider all material risk factors, including when applicable the lines of business involved, the stability of the incurred loss estimates and the effect of the surplus requirements on the assuming insurer's liquidity or solvency. The minimum required trusteed surplus may not be reduced to an amount less than thirty percent (30%) of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers covered by the trust;

(B) A group including incorporated and individual unincorporated underwriters, the trust shall consist

of a trusteed account representing the group's liabilities attributable to business written in the United States and, in addition:

(I) The group shall maintain a trusteed surplus of which one hundred million dollars ($100,000,000.00) shall be held jointly for the benefit of United States ceding insurers of any member of the group;

(II) Within ninety (90) days after its financial statements are due, the group shall make available to the commissioner an annual certification of the solvency of each underwriter by the group's domiciliary regulator and its independent public accountants; and

(III) The incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of solvency regulation and control by the group's domiciliary regulator as are the unincorporated members.

(vi) The reinsurance is ceded to an assuming insurer that is certified by the commissioner as a reinsurer in this state and secures its obligations in accordance with the following provisions:

(A) Prior to certification by the commissioner, the assuming insurer must be eligible for certification. In order to be eligible for certification, the assuming insurer shall:

(I) Be domiciled and licensed to transact insurance or reinsurance in a qualified jurisdiction, as determined by the commissioner pursuant to subparagraph (C) of this paragraph;

(II) Maintain minimum capital and surplus, or its equivalent, in an amount to be determined by rule and regulation of the commissioner;

(III) Maintain financial strength ratings from two (2) or more rating agencies deemed acceptable by rule and regulation of the commissioner;

(IV) Agree to submit to the jurisdiction of this state, appoint the commissioner as its agent for service of process in this state and agree to provide security for one

hundred percent (100%) of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers if it resists enforcement of a final United States judgment;

(V) Agree to meet applicable information filing requirements as determined by the commissioner, both with respect to an initial application for certification and on an ongoing basis; and

(VI) Satisfy any other requirements for certification deemed necessary by the commissioner.

(B) Prior to certification by the commissioner, an association including incorporated and individual unincorporated underwriters must be eligible for certification by the commissioner. In order to be eligible for certification, an association must satisfy the requirements of subparagraph (A) of this paragraph and comply with the following requirements:

(I) The association shall satisfy its minimum capital and surplus requirements through the capital and surplus equivalents, taking into account liabilities, of the association and its members, which shall include a joint central fund that may be applied to any unsatisfied obligation of the association or any of its members, in an amount determined by the commissioner to provide adequate protection;

(II) The incorporated members of the association shall not be engaged in any business other than underwriting as a member of the association and shall be subject to the same level of regulation and solvency control by the association's domiciliary regulator as are the unincorporated members; and

(III) Within ninety (90) days after its financial statements are due to be filed with the association's domiciliary regulator, the association shall provide to the commissioner an annual certification by the association's domiciliary regulator of the solvency of each underwriter member or, if a certification is unavailable, financial statements, prepared by independent public accountants, of each underwriter member of the association.

(C) Prior to certification, the assuming insurer must be licensed and domiciled in a jurisdiction eligible to be considered for certification by the commissioner. The

commissioner shall create and publish a list of qualified jurisdictions, under which an assuming insurer licensed and domiciled in such jurisdiction is eligible to be considered for certification by the commissioner as a certified reinsurer. The commissioner shall:

(I) In order to determine whether the domiciliary jurisdiction of a non United States assuming insurer is eligible to be recognized as a qualified jurisdiction, evaluate the appropriateness and effectiveness of the reinsurance supervisory system of the jurisdiction, both initially and on an ongoing basis, and consider the rights, benefits and the extent of reciprocal recognition afforded by the non United States jurisdiction to reinsurers licensed and domiciled in the United States. A qualified jurisdiction shall agree to share information and cooperate with the commissioner with respect to all certified reinsurers domiciled within that jurisdiction. A jurisdiction shall not be recognized as a qualified jurisdiction if the commissioner has determined that the jurisdiction does not adequately and promptly enforce final United States judgments and arbitration awards. Additional factors may be considered in the discretion of the commissioner;

(II) Consider the list of qualified jurisdictions published through the NAIC committee process in determining qualified jurisdictions. If the commissioner approves a jurisdiction as qualified that does not appear on the list of qualified jurisdictions, the commissioner shall provide thoroughly documented justification in accordance with criteria developed under rule and regulation developed by the commissioner;

(III) Recognize as qualified jurisdictions the United States jurisdictions that meet the requirement for accreditation under the NAIC financial standards and accreditation program;

(IV) If a certified reinsurer's domiciliary jurisdiction ceases to be a qualified jurisdiction, have the discretion to suspend the reinsurer's certification indefinitely, in lieu of revocation.

(D) Each certified reinsurer must receive a financial rating from the commissioner. The commissioner shall assign a rating to each certified reinsurer giving due consideration to the financial strength ratings that have been assigned by rating agencies deemed acceptable to the

commissioner pursuant to regulation. The commissioner shall publish a list of all certified reinsurers and their ratings;

(E) A certified reinsurer shall secure obligations assumed from United States ceding insurers under this paragraph at a level consistent with its rating and as specified by rule and regulation promulgated by the commissioner. In fulfilling the requirements of this subparagraph:

(I) In order for a domestic ceding insurer to qualify for full financial statement credit for reinsurance ceded to a certified reinsurer, the certified reinsurer shall maintain security in a form acceptable to the commissioner and consistent with the provisions of W.S. 26-5-113, or in a multibeneficiary trust in accordance with paragraph (v) of this subsection and subsection (b) of this section, except as otherwise provided in this paragraph;

(II) If a certified reinsurer maintains a trust to fully secure its obligations subject to paragraph (v) of this subsection and subsection (b) of this section and chooses to secure its obligations incurred as a certified reinsurer in the form of a multibeneficiary trust, the certified reinsurer shall maintain separate trust accounts for its obligations incurred under reinsurance agreements issued or renewed as a certified reinsurer with reduced security as permitted by this paragraph or comparable laws of other United States jurisdictions and for its obligations subject to paragraph (v) of this subsection and subsection (b) of this section. It shall be a condition to the grant of certification under this paragraph that the certified reinsurer have bound itself, by the language of the trust and agreement with the commissioner with principal regulatory oversight of each trust account, to fund, upon termination of any trust account, out of the remaining surplus of the trust any deficiency of any other trust account;

(III) The minimum trusteed surplus requirements provided in paragraph (v) of this subsection are not applicable with respect to a multibeneficiary trust maintained by a certified reinsurer for the purpose of securing obligations incurred under this paragraph, except that any trust shall maintain a minimum trusteed surplus of ten million dollars ($10,000,000.00);

(IV) With respect to obligations incurred by a certified reinsurer under this paragraph, if the security is insufficient, the commissioner shall reduce the allowable credit by an amount proportionate to the deficiency and may impose further reductions in allowable credit upon finding there is a material risk the certified reinsurer's obligations will not be paid in full when due;

(V) For purposes of this paragraph, a certified reinsurer whose certification has been terminated for any reason shall be treated as a certified reinsurer required to secure one hundred percent (100%) of its obligations. If the commissioner continues to assign a higher rating as permitted by other provisions of this section, this requirement does not apply to a certified reinsurer in inactive status or to a reinsurer whose certification has been suspended. As used in this subdivision, "terminated" refers to revocation, suspension, voluntary surrender and inactive status.

(F) If an applicant for certification has been certified as a reinsurer in an NAIC accredited jurisdiction, the commissioner may defer to that jurisdiction's certification and may defer to the rating assigned by that jurisdiction, and the assuming insurer shall be considered to be a certified reinsurer in this state;

(G) A certified reinsurer that ceases to assume new business in this state may request to maintain its certification in inactive status in order to continue to qualify for a reduction in security for its in-force business. An inactive certified reinsurer shall continue to comply with all applicable requirements of this paragraph, and the commissioner shall assign a rating that takes into account the reasons why the reinsurer is not assuming new business, if relevant.

(vii) When the reinsurance is ceded to an assuming insurer in accordance with the following:

(A) The assuming insurer has its head office or is domiciled in a reciprocal jurisdiction, as applicable, and is licensed in a reciprocal jurisdiction;

(B) The assuming insurer has and maintains, on an ongoing basis, minimum capital and surplus, or its equivalent, calculated according to the methodology of its domiciliary jurisdiction in an amount specified in rules adopted by the commissioner. If the assuming insurer is an association,

including incorporated and individual unincorporated underwriters, it shall have and maintain, on an ongoing basis, minimum capital and surplus equivalents, which are net of liabilities, calculated according to the methodology applicable in its domiciliary jurisdiction and a central fund containing a balance in amounts specified in rules adopted by the commissioner;

(C) The assuming insurer has and maintains, on an ongoing basis, a minimum solvency or capital ratio, as applicable, as specified in rules adopted by the commissioner. If the assuming insurer is an association, including incorporated and individual unincorporated underwriters, it shall have and maintain, on an ongoing basis, a minimum solvency or capital ratio in the reciprocal jurisdiction where the assuming insurer has its head office or is domiciled, as applicable, and is also licensed;

(D) The assuming insurer agrees and provides adequate assurance to the commissioner, in a form specified by rules adopted by the commissioner, that:

(I) The assuming insurer shall provide prompt written notice and explanation to the commissioner if it falls below the minimum requirements set forth in subparagraphs (B) or (C) of this paragraph, or if any regulatory action is taken against it for serious noncompliance with applicable law;

(II) The assuming insurer shall consent in writing to the jurisdiction of the courts of this state and to the appointment of the commissioner as agent for service of process. The commissioner may require that consent for service of process be provided to the commissioner and included in each reinsurance agreement. Nothing in this subdivision shall limit or in any way alter the capacity of parties to a reinsurance agreement to agree to alternative dispute resolution mechanisms, except to the extent such agreements are unenforceable under applicable insolvency or delinquency laws;

(III) The assuming insurer shall consent in writing to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer or its legal successor, that have been declared enforceable in the jurisdiction where the judgment was obtained;

(IV) Each reinsurance agreement shall require the assuming insurer to provide security in an amount

equal to one hundred percent (100%) of the assuming insurer's liabilities attributable to reinsurance ceded pursuant to that agreement if the assuming insurer resists enforcement of a final judgment applicable to the reinsurance ceded pursuant to that agreement that is enforceable under the law of the jurisdiction in which it was obtained or a properly enforceable arbitration award, whether obtained by the ceding insurer or by its legal successor on behalf of its resolution estate; and

(V) The assuming insurer shall confirm that it is not presently participating in any solvent scheme of arrangement which involves this state's ceding insurers. It shall also agree to notify the ceding insurer and the commissioner and to provide security in an amount equal to one hundred percent (100%) of the assuming insurer's liabilities to the ceding insurer should the assuming insurer enter into such a solvent scheme of arrangement. Such security shall be in a form consistent with the provisions of paragraph (vi) of this subsection, W.S. 26-5-113 and rules adopted by the commissioner.

(E) The assuming insurer or its legal successor shall provide, if requested by the commissioner, on behalf of itself and any legal predecessors, documentation to the commissioner as specified by rules adopted by the commissioner;

(F) The assuming insurer shall maintain a practice of prompt payment of claims under reinsurance agreements pursuant to criteria set forth in rules adopted by the commissioner;

(G) The assuming insurer's supervisory authority shall confirm to the commissioner on an annual basis, as of the preceding December 31 or at the annual date otherwise statutorily reported to the reciprocal jurisdiction, that the assuming insurer complies with the requirements set forth in subparagraphs (B) and (C) of this paragraph;

(H) Nothing in this paragraph precludes an assuming insurer from providing the commissioner with information on a voluntary basis;

(J) The commissioner shall timely create and publish a list of reciprocal jurisdictions. The commissioner's list shall include any reciprocal jurisdiction as defined under subparagraphs (j)(ii)(A) and (B) of this section and the commissioner shall consider adding any other reciprocal jurisdiction included on the NAIC list of reciprocal

jurisdictions published through the NAIC committee process. The commissioner may approve a jurisdiction as a reciprocal jurisdiction that does not appear on the NAIC list of reciprocal jurisdictions in accordance with criteria specified in rules adopted by the commissioner. The commissioner may remove a jurisdiction from the list of reciprocal jurisdictions upon a determination that the jurisdiction no longer meets the requirements of a reciprocal jurisdiction, in accordance with a process set forth in rules adopted by the commissioner, except that the commissioner shall not remove from the list a reciprocal jurisdiction as defined under subparagraph (j)(ii)(A) or (B) of this section. Upon removal of a reciprocal jurisdiction from this list, credit for reinsurance ceded to an assuming insurer which has its home office or is domiciled in that jurisdiction shall be allowed if otherwise allowed pursuant to this chapter;

(K) The commissioner shall timely create and publish a list of assuming insurers that have satisfied all conditions set forth in this paragraph and to which cessions shall be granted credit in accordance with this subsection. The commissioner may add an assuming insurer to the list if an NAIC accredited jurisdiction has added the assuming insurer to a list of such assuming insurers or if, upon initial eligibility, the assuming insurer submits the information to the commissioner as required under subparagraph (D) of this paragraph and complies with any additional requirements that the commissioner may impose by rule, except to the extent that they conflict with an applicable covered agreement;

(M) If the commissioner determines that an assuming insurer no longer meets one (1) or more of the requirements under this paragraph, the commissioner may revoke or suspend the eligibility of the assuming insurer for recognition under this paragraph in accordance with procedures set forth in rules adopted by the commissioner. While an assuming insurer's eligibility is suspended, no reinsurance agreement issued, amended or renewed after the effective date of the suspension qualifies for credit except to the extent that the assuming insurer's obligations under the contract are secured in accordance with W.S. 26-5-113. If an assuming insurer's eligibility is revoked, no credit for reinsurance may be granted after the effective date of the revocation with respect to any reinsurance agreements entered into by the assuming insurer, including reinsurance agreements entered into prior to the date of revocation, except to the extent that the assuming insurer's obligations under the contract are secured in

a form acceptable to the commissioner and consistent with the provisions of W.S. 26-5-113;

(N) If subject to a legal process of rehabilitation, liquidation or conservation, as applicable, the ceding insurer or its representative may seek and, if determined appropriate by the court in which the proceedings are pending, may obtain an order requiring that the assuming insurer post security for all outstanding ceded liabilities;

(O) Nothing in this paragraph shall limit or in any way alter the capacity of parties to a reinsurance agreement to agree on requirements for security or other terms in that reinsurance agreement, except as expressly prohibited by this chapter or other applicable law or rule;

(P) Credit may be taken under this paragraph only for reinsurance agreements entered into, amended, or renewed on or after July 1, 2021 and only with respect to losses incurred and reserves reported on or after the later of the date on which the assuming insurer has met all eligibility requirements of this paragraph and the effective date of the new reinsurance agreement, amendment or renewal. This subparagraph does not alter or impair a ceding insurer's right to take credit for reinsurance, to the extent that credit is not available under this paragraph, as long as the reinsurance qualifies for credit under any other applicable provision of this chapter;

(Q) Nothing in this paragraph shall authorize an assuming insurer to withdraw or reduce the security provided under any reinsurance agreement except as permitted by the terms of the agreement;

(R) Nothing in this paragraph shall limit, or in any way alter, the capacity of parties to any reinsurance agreement to renegotiate the agreement.

(b) A trust under paragraph (a)(v) of this section shall be established in a form approved by the commissioner. The trust instrument shall provide that contested claims shall be valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust shall vest legal title to its assets in the trustees of the trust for its United States policyholders and ceding insurers, their assigns and successors in interest. The trust and the assuming insurer shall be subject to examination as determined by the commissioner. The trust described herein shall remain in effect

for as long as the assuming insurer shall have outstanding obligations due under the reinsurance agreements subject to the trust. No later than February 28 of each year the trustees of the trust shall report to the commissioner in writing setting forth the balance of the trust and listing the trust's investments at the preceding year end and shall certify the date of termination of the trust, if so planned, or certify that the trust shall not expire prior to the next following December 31.

(c) If the assuming insurer is not licensed, certified or accredited to transact insurance or reinsurance in this state, the credit permitted by paragraphs (a)(iii) and (v) of this section shall not be allowed unless the assuming insurer agrees in the reinsurance agreements:

(i) That in the event of the failure of the assuming insurer to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, shall submit to the jurisdiction of any court of competent jurisdiction in any state of the United States, shall comply with all requirements necessary to give the court jurisdiction, and shall abide by the final decision of the court or of any appellate court in the event of an appeal; and

(ii) To designate the commissioner as its true and lawful attorney upon whom may be served any lawful process in any action, suit or proceeding instituted by or on behalf of the ceding insurer.

(d) Subsection (c) of this section shall not supersede the obligation of the parties to a reinsurance agreement to arbitrate their disputes, if such an obligation is created in the agreement.

(e) If an accredited or certified reinsurer ceases to meet the requirements for accreditation or certification, the commissioner may suspend or revoke the reinsurer's accreditation or certification in accordance with the following:

(i) The commissioner shall give the reinsurer notice and opportunity for hearing. The suspension or revocation shall not take effect until after the commissioner's order on hearing, unless:

(A) The reinsurer waives its right to a hearing;

(B) The commissioner's order is based on regulatory action by the reinsurer's domiciliary jurisdiction or the voluntary surrender or termination of the reinsurer's eligibility to transact insurance or reinsurance business in its domiciliary jurisdiction or in the primary certifying state of the reinsurer under subparagraph (a)(vi)(F) of this section; or

(C) The commissioner finds that an emergency requires immediate action and a court of competent jurisdiction has not stayed the commissioner's action.

(ii) While a reinsurer's accreditation or certification is suspended, no reinsurance contract issued or renewed after the effective date of the suspension qualifies for credit except to the extent that the reinsurer's obligations under the contract are secured in accordance with W.S. 26-5-113. If a reinsurer's accreditation or certification is revoked, no credit for reinsurance may be granted after the effective date of the revocation except to the extent that the reinsurer's obligations under the contract are secured in accordance with subparagraph (a)(vi)(E) of this section or W.S. 26-5-113.

(f) A ceding insurer shall take steps to manage its reinsurance recoverables proportionate to its own book of business. A domestic ceding insurer shall notify the commissioner within thirty (30) days after reinsurance recoverables from any single assuming insurer or group of affiliated assuming insurers exceeds fifty percent (50%) of the domestic ceding insurer's last reported surplus to policyholders, or after it is determined that reinsurance recoverables from any single assuming insurer or group of affiliated assuming insurers is likely to exceed this limit. The notification shall demonstrate that the exposure is safely managed by the domestic ceding insurer.

(g) A ceding insurer shall take steps to diversify its reinsurance program. A domestic ceding insurer shall notify the commissioner within thirty (30) days after ceding to any single assuming insurer or group of affiliated assuming insurers more than twenty percent (20%) of the ceding insurer's gross written premium in the prior calendar year, or after it has determined that the reinsurance ceded to any single assuming insurer or group of affiliated assuming insurers is likely to exceed this limit. The notification shall demonstrate the exposure is safely managed by the domestic ceding insurer.

(h) Credit for reinsurance ceded to a certified reinsurer is limited to reinsurance contracts entered or renewed on or after the effective date of the certification of the assuming insurer by the commissioner.

(j) As used in this section:

(i) "Covered agreement" means an agreement entered into pursuant to the Dodd-Frank Wall Street Reform and Consumer Protection Act, 31 U.S.C. §§ 313 and 314, that is currently in effect or in a period of provisional application and that addresses the elimination, under specified conditions, of collateral requirements as a condition for entering into any reinsurance agreement with a ceding insurer domiciled in this state or for allowing the ceding insurer to recognize credit for reinsurance;

(ii) "Reciprocal jurisdiction" means any of the following:

(A) A non-United States jurisdiction that is subject to an in-force covered agreement with the United States, each within its legal authority, or, in the case of a covered agreement between the United States and the European Union, is a member state of the European Union;

(B) A United States jurisdiction that meets the requirements for accreditation under the NAIC financial standards and accreditation program;

(C) A qualified jurisdiction, as determined by the commissioner pursuant to subparagraph (a)(vi)(C) of this section, that is not otherwise described in subparagraphs (A) or (B) of this paragraph and that meets certain additional requirements, consistent with the terms and conditions of in-force covered agreements, as specified in rules adopted by the commissioner.

26-5-113. Reduction from liability for reinsurance ceded by a domestic insurer to an assuming insurer.

(a) A reduction from liability for the reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of W.S. 26-5-112 shall be allowed in an amount not exceeding the liabilities carried by the ceding insurer, provided that the commissioner may adopt rules and regulations establishing additional requirements relating to or setting

forth the valuation of assets or reserve credits, the amount and forms of security supporting reinsurance arrangements described in W.S. 26-5-116 and the circumstances pursuant to which credit will be reduced or eliminated. The reduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with the assuming insurer as security for the payment of obligations thereunder, if the security is held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer, or, in the case of a trust, held in a qualified United States financial institution, as defined in W.S. 26-5-114(b). This security may be in the form of:

(i) Cash;

(ii) Securities listed by the securities valuation office of the NAIC, including those deemed exempt from filing as defined by the purposes and procedures manual of the NAIC securities valuation office, and qualifying as admitted assets;

(iii) Clean, irrevocable, unconditional letters of credit issued or confirmed by a qualified United States institution no later than December 31 in respect of the year for which filing is being made, and in the possession of the ceding insurer on or before the filing date of its annual statement. Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance or confirmation shall, notwithstanding the issuing or confirming institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification or amendment, whichever first occurs; or

(iv) Any other form of security acceptable to the commissioner.

26-5-114. Qualified United States financial institutions.

(a) For purposes of W.S. 26-5-113(a)(iii), a "qualified United States financial institution" means an institution that:

(i) Is organized or, in the case of a United States office of a foreign banking organization licensed, under the laws of the United States or any state thereof;

(ii) Is regulated, supervised and examined by United States federal or state authorities having regulatory authority over banks and trust companies; and

(iii) Has been determined by either the commissioner, or the securities valuation office of the National Association of Insurance Commissioners, to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the commissioner.

(b) A "qualified United States financial institution" means, for purposes of those provisions of W.S. 26-5-112 and 26-5-113 specifying those institutions that are eligible to act as a fiduciary of a trust, an institution that:

(i) Is organized or, in the case of a United States branch or agency office of a foreign banking organization licensed, under the laws of the United States or any state thereof and has been granted authority to operate with fiduciary powers; and

(ii) Is regulated, supervised and examined by federal or state authorities having regulatory authority over banks and trust companies.

26-5-115. Reinsurance payable without diminution due to insolvency of ceding insurer.

No credit or reduction of liability for reinsurance ceded under W.S. 26-5-112 or 26-5-113 shall be allowed unless the agreement provides that the reinsurance is payable by the assuming insurer on the basis of the liability of the ceding insurer without diminution due to the insolvency of the ceding insurer.

26-5-116. Rules and regulations; reporting.

(a) The commissioner may adopt rules and regulations implementing the provisions of W.S. 26-5-111 through 26-5-117.

(b) Upon the commissioner's request, an insurer shall promptly inform him in writing of the cancellation or any other material change of any of its reinsurance treaties or arrangements.

(c) In addition to the authority provided by subsection (a) of this section, the commissioner may adopt rules and

regulations applicable to reinsurance arrangements. A regulation adopted pursuant to this subsection may apply only to reinsurance relating to:

(i) Life insurance policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits;

(ii) Universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period;

(iii) Variable annuities with guaranteed death or living benefits;

(iv) Long-term care insurance policies; or

(v) Any other life and health insurance and annuity products as to which the NAIC adopts model regulatory requirements with respect to credit for reinsurance.

(d) A regulation adopted pursuant to paragraph (c)(i) or (ii) of this section may apply to a treaty containing policies issued on or after January 1, 2015 and policies issued prior to January 1, 2015 if the risk pertaining to the policies issued prior to January 1, 2015 is ceded in connection with the treaty, in whole or in part, on or after January 1, 2015.

(e) A regulation adopted pursuant to subsection (c) of this section may require the ceding insurer, in calculating the amounts or forms of security required to be held under rules promulgated under this section, to use the valuation manual adopted by the NAIC under section 11B(1) of the NAIC standard valuation law, including all amendments adopted by the NAIC and in effect on the date the calculation is made, to the extent applicable.

(f) A regulation adopted pursuant to subsection (c) of this section shall not apply to cessions to an assuming insurer that:

(i) Meets the conditions set forth in W.S. 26-5-112(a)(vii) or, if this state has not adopted provisions substantially equivalent to section 2F of the Credit for Reinsurance Model Law, the assuming insurer is operating in accordance with provisions substantially equivalent to section 2F of the Credit for Reinsurance Model Law in a minimum of five (5) other states;

(ii) Is certified in this state or, if this state has not adopted provisions substantially equivalent to section 2E of the Credit for Reinsurance Model Law, certified in a minimum of five (5) other states; or

(iii) Maintains at least two hundred fifty million dollars ($250,000,000.00) in capital and surplus when determined in accordance with the NAIC accounting practices and procedures manual, including all amendments adopted by the NAIC, excluding the impact of any permitted or prescribed practices, and is:

(A) Licensed in at least twenty-six (26) states; or

(B) Licensed in at least ten (10) states and licensed or accredited in a total of at least thirty-five (35) states.

(g) The authority to adopt rules pursuant to subsection (c) of this section does not limit the commissioner's general authority to adopt rules pursuant to subsection (a) of this section.

26-5-117. Reinsurance agreements affected.

W.S. 26-5-112 through 26-5-116 shall apply to all cessions after the effective date of this act under reinsurance agreements which have had an inception, anniversary or renewal date not less than six (6) months after the effective date of this act.

26-5-118. Repealed by Laws 1994, ch. 76, § 3.

26-5-119. Life and disability reinsurance agreements; limitations.

(a) This section shall apply to all domestic life and domestic disability insurers and to all other licensed life and disability insurers which are not subject to a substantially similar law or regulation in their domiciliary state. This section shall also similarly apply to licensed property and casualty insurers with respect to their accident and health business. This section shall not apply to assumption reinsurance, yearly renewable term reinsurance or certain nonproportional reinsurance such as stop loss or catastrophe reinsurance.

(b)(i) No insurer subject to this section shall, for reinsurance ceded, reduce any liability or establish any asset in any financial statement filed with the department if, by the terms of the reinsurance agreement, in substance or effect, any of the following conditions exist:

(A) Renewal expense allowances provided or to be provided to the ceding insurer by the reinsurer in any accounting period, are not sufficient to cover anticipated allocable renewal expenses of the ceding insurer on the portion of the business reinsured, unless a liability is established for the present value of the shortfall using assumptions equal to the applicable statutory reserve basis on the business reinsured. Those expenses include commissions, premium taxes and direct expenses including, but not limited to, billing, valuation, claims and maintenance expected by the company at the time the business is reinsured;

(B) The ceding insurer can be deprived of surplus or assets at the reinsurer's option or automatically upon the occurrence of some event, such as the insolvency of the ceding insurer, except that termination of the reinsurance agreement by the reinsurer for nonpayment of reinsurance premiums or other amounts due, such as modified coinsurance reserve adjustments, interest and adjustments on funds withheld, and tax reimbursements shall not be considered to be a deprivation of surplus or assets;

(C) The ceding insurer is required to reimburse the reinsurer for negative experience under the reinsurance agreement. Offsetting experience refunds against current and prior years' losses under the agreement or payment by the ceding insurer of an amount equal to the current and prior years' losses under the agreement upon voluntary termination of in-force reinsurance by the ceding insurer shall not be considered a reimbursement to the reinsurer for negative experience. Voluntary termination does not include situations where termination occurs because of unreasonable provisions which allow the reinsurer to reduce its risk under the agreement;

(D) The ceding insurer must, at specific points in time scheduled in the agreement, terminate or automatically recapture all or part of the reinsurance ceded;

(E) The reinsurance agreement involves the possible payment by the ceding insurer to the reinsurer of

amounts other than from income realized from the reinsured policies;

(F) The treaty does not transfer all of the significant risk inherent in the business being reinsured. The following table identifies for a representative sampling of products or type of business, the risks which are considered to be significant. For products not specifically included, the risks determined to be significant shall be consistent with this table. The risk categories are:

(I) Morbidity;

(II) Mortality;

(III) Lapse, meaning the risk that a policy will voluntarily terminate prior to the recoupment of a statutory surplus strain experienced at issue of the policy;

(IV) Credit quality, meaning the risk that invested assets supporting the reinsured business will decrease in value. The main hazards are that assets will default or that there will be a decrease in earning power. Credit quality excludes market value declines due to changes in interest rate;

(V) Reinvestment, meaning the risk that interest rates will fall and funds reinvested coupon payments or monies received upon asset maturity or call will therefore earn less than expected. If asset durations are less than liability durations, the mismatch will increase;

(VI) Disintermediation, meaning the risk that interest rates rise and policy loans and surrenders increase or maturing contracts do not renew at anticipated rates of renewal.

TYPE OF INSURANCE	RISK CATEGORY					
	I	II	III	IV	V	VI
Health Insurance-other than long term care insurance or long term disability insurance	+	0	+	0	0	0
Health Insurance-long term care	+	0	+	+	+	0

insurance or long term disability insurance						
Immediate Annuities	0	+	0	+	+	0
Single Premium Deferred Annuities	0	0	+	+	+	+
Flexible Premium Deferred Annuities	0	0	+	+	+	+
Guaranteed Interest Contracts	0	0	0	+	+	+
Other Annuity Deposit Business	0	0	+	+	+	+
Single Premium Whole Life	0	+	+	+	+	+
Traditional Non-Par Permanent	0	+	+	+	+	+
Traditional Non-Par Term	0	+	+	0	0	0
Traditional Par Permanent	0	+	+	+	+	+
Traditional Par Term	0	+	+	0	0	0
Adjustable Premium Permanent	0	+	+	+	+	+
Indeterminate Premium Permanent	0	+	+	+	+	+
Universal Life Flexible Premium	0	+	+	+	+	+
Universal Life Fixed Premium	0	+	+	+	+	+
Universal Life Fixed Premium dump-in premiums allowed	0	+	+	+	+	+

+ - Significant

0 - Insignificant

(G)(I) The credit quality, reinvestment or disintermediation risk is significant for the business reinsured and the ceding company does not, other than for the classes of business excepted in subdivision (G)(II) of this paragraph

either transfer the underlying assets to the reinsurer, legally segregate such assets in a trust or escrow account or otherwise establish a mechanism which legally segregates, by contract or contract provision, the underlying assets;

(II) Notwithstanding the requirements of subdivision (G)(I) of this paragraph, the assets supporting the reserves for the following classes of business and any classes of business which do not have a significant credit quality, reinvestment or disintermediation risk may be held by the ceding company without segregation of the assets:

(1) Health insurance-long term care or long term disability;

(2) Traditional nonparticipating permanent;

(3) Traditional participating permanent;

(4) Adjustable premium permanent;

(5) Indeterminate premium permanent;

(6) Universal life fixed premium, with no dump-in premiums allowed.

(III) The associated formula for determining the reserve interest rate adjustment shall use a formula which reflects the ceding company's investment earnings and incorporates all realized and unrealized gains and losses reflected in the statutory statement. The following is an acceptable formula:

$$\text{Rate} = 2(I + CG)/X + Y-I-CG$$

Where: I is the net investment income

CG is capital gains less capital losses

X is the current year cash and invested assets plus investment income due and accrued less borrowed money

Y is the same as X but for the prior year

(H) Settlements are made less frequently than quarterly or payments due from the reinsurer are not made in cash within ninety (90) days of the settlement date;

(J) The ceding insurer is required to make representations or warranties not reasonably related to the business being reinsured;

(K) The ceding insurer is required to make representations or warranties about future performance of the business being reinsured;

(M) The reinsurance agreement is entered into for the principal purpose of producing significant surplus aid for the ceding insurer while not transferring all of the significant risks inherent in the business reinsured and, in substance or effect, the expected potential liability to the ceding insurer remains basically unchanged.

(ii) Notwithstanding paragraph (i) of this subsection, an insurer subject to this section may, with the prior approval of the commissioner, take reserve credit or establish assets the commissioner deems consistent with this code, rules or regulations, including actuarial interpretations or standards adopted by the department;

(iii)(A) Agreements entered into after April 1, 1994 which involve the reinsurance of business issued prior to the effective date of the agreements, along with any subsequent amendments thereto, shall be filed by the ceding company with the commissioner within thirty (30) days from their date of execution. Each filing shall include data detailing the financial impact of the transaction. The ceding insurer's actuary who signs the financial statement actuarial opinion with respect to valuation of reserves shall consider this section and any applicable actuarial standards of practice when determining the proper credit in financial statements filed with the department. The actuary shall maintain adequate documentation and be prepared upon request to describe the actuarial work performed for inclusion in the financial statements and to demonstrate that the work conforms to this section;

(B) Any increase in surplus net of federal income tax resulting from arrangements described in subparagraph (A) of this paragraph shall be identified separately on the

insurer's statutory financial statement as a surplus item with aggregate write-ins for gains and losses in surplus in the capital and surplus account, and recognition of the surplus increase as income shall be reflected on a net of tax basis in the "reinsurance ceded" line, of the annual statement as earnings emerge from the business reinsured.

(c)(i) No reinsurance agreement or amendment to any agreement shall be used to reduce any liability or to establish any asset in any financial statement filed with the department, unless the agreement, amendment or a binding letter of intent has been duly executed by both parties no later than the "as of date" of the financial statement;

(ii) In the case of a letter of intent, a reinsurance agreement or an amendment to a reinsurance agreement must be executed within a reasonable period of time, not exceeding ninety (90) days from the execution date of the letter of intent, in order for credit to be granted for the reinsurance ceded;

(iii) The reinsurance agreement shall contain provisions which provide that:

(A) The agreement shall constitute the entire agreement between the parties with respect to the business being reinsured thereunder and that there are no understandings between the parties other than as expressed in the agreement; and

(B) Any change or modification to the agreement shall be null and void unless made by amendment to the agreement and signed by both parties.

(d) Insurers subject to this section shall reduce to zero (0) by December 31, 1995 any reserve credits or assets established with respect to reinsurance agreements entered into prior to April 1, 1994 which, under the provisions of this section would not be entitled to recognition of the reserve credits or assets, provided, however, that the reinsurance agreements shall have been in compliance with laws or regulations in existence immediately preceding the effective date of this section.

(e) The commissioner may promulgate reasonable rules and regulations and issue orders necessary to implement the provisions of this section.

CHAPTER 6 - ASSETS AND LIABILITIES

ARTICLE 1 - ASSETS AND LIABILITIES GENERALLY

26-6-101. Assets allowed.

(a) In any determination of an insurer's financial condition, only the insurer owned assets set forth and allowed in the most recent National Association of Insurance Commissioners' accounting practices and procedures manual or authorized in accordance with this section shall be allowed as assets. Assets not inconsistent with this article shall be allowed at values the commissioner determines, if he deems them available for the payment of losses and claims.

(i) Repealed By Laws 2001, Ch. 9, § 2.

(ii) Repealed By Laws 2001, Ch. 9, § 2.

(iii) Repealed By Laws 2001, Ch. 9, § 2.

(iv) Repealed By Laws 2001, Ch. 9, § 2.

(v) Repealed By Laws 2001, Ch. 9, § 2.

(vi) Repealed By Laws 2001, Ch. 9, § 2.

(vii) Repealed By Laws 2001, Ch. 9, § 2.

(viii) Repealed By Laws 2001, Ch. 9, § 2.

(ix) Repealed By Laws 2001, Ch. 9, § 2.

(x) Repealed By Laws 2001, Ch. 9, § 2.

(xi) Repealed By Laws 2001, Ch. 9, § 2.

(xii) Repealed By Laws 2001, Ch. 9, § 2.

(xiii) Repealed By Laws 2001, Ch. 9, § 2.

(xiv) Repealed By Laws 2001, Ch. 9, § 2.

26-6-102. Assets not allowed.

(a) In addition to assets impliedly excluded by the most recent National Association of Insurance Commissioners' accounting practices and procedures manual pursuant to W.S. 26-6-101, the following are not allowed as assets in any determination of an insurer's financial condition:

(i) Goodwill, trade names and other similar intangible assets;

(ii) Repealed By Laws 2001, Ch. 9, § 2.

(iii) Repealed By Laws 2001, Ch. 9, § 2.

(iv) Repealed By Laws 2001, Ch. 9, § 2.

(v) Repealed By Laws 2001, Ch. 9, § 2.

26-6-103. Liabilities generally.

(a) In any determination of an insurer's financial condition, capital stock and liabilities to be charged against its assets include the capital stock and liability items set forth in the most recent National Association of Insurance Commissioners' accounting practices and procedures manual and the following:

(i) The amount of its capital stock outstanding, if any;

(ii) The amount, estimated consistent with this code, necessary to pay all of its unpaid losses and claims incurred on or prior to the date of statement together with the expenses of adjustment or settlement thereof;

(iii) Concerning life insurance and annuity contracts and disability and accidental death benefits in or supplemental thereto:

(A) The amount of reserves on life insurance policies and annuity contracts in force, valued according to the mortality tables, rates of interest and methods adopted pursuant to this code which are applicable thereto;

(B) Reserves for disability benefits for both active and disabled lives;

(C) Reserves for accidental death benefits;

(D) Any additional reserves the commissioner requires consistent with applicable customary and general practice in insurance accounting.

(iv) Concerning disability insurance, the reserves required under W.S. 26-6-107;

(v) Concerning insurance other than specified in paragraphs (iii) and (iv) of this subsection, and other than title insurance, the amount of reserves equal to the unearned portions of the gross premiums charged on policies in force, computed in accordance with this chapter;

(vi) Taxes, expenses and other obligations due or accrued at the date of the statement.

26-6-104. Disallowance of "wash" transactions.

(a) The commissioner, after a hearing thereon, shall disallow as an asset or as a credit against liabilities any reinsurance he finds to have been arranged principally for the purpose of deception as to the ceding insurer's financial condition on the date of an insurer's financial statement. Without limiting the general purport of this provision, reinsurance of any substantial part of the insurer's outstanding risks contracted for in fact within four (4) months prior to the date of a financial statement and cancelled after the date of that statement, or reinsurance under which the reinsurer bears no substantial insurance risk or chance of net loss to itself, is prima facie evidence of an arrangement principally for the purpose of deception.

(b) The commissioner, after a hearing thereon, shall disallow as an insurer's asset any deposit, funds or other assets he finds:

(i) Not to be in good faith the insurer's property;

(ii) Not freely subject to the insurer's withdrawal or liquidation at any time for the payment or discharge of claims or other obligations arising under its policies; and

(iii) To be resulting from arrangements made principally for the purpose of deception as to the insurer's financial condition on the date of any financial statement of the insurer.

(c) The commissioner may suspend or revoke the certificate of authority of any insurer which has knowingly been a party to any actual or attempted deception.

26-6-105. Unearned premium reserve; generally.

(a) As to property, casualty and surety insurances the insurer shall maintain an unearned premium reserve on all policies in force as required under regulations adopted by the commissioner. In promulgating regulations under this subsection, the commissioner shall take into consideration standards recommended by the National Association of Insurance Commissioners Accounting Practices and Procedures Manual.

(b) Repealed By Laws 2000, Ch. 57, § 2.

26-6-106. Unearned premium reserve; marine and transportation insurance.

As to marine and transportation insurance, the unearned premium reserve shall be determined pursuant to the most recent National Association of Insurance Commissioners' accounting practices and procedures manual.

26-6-107. Unearned premium reserve; reserve for disability insurance.

For all disability insurance policies the insurer shall maintain an active life reserve which shall place a sound value on its liabilities under those policies and be not less than the reserve according to appropriate standards set forth in regulations the commissioner issues, but not less in the aggregate than the pro rata gross unearned premiums for the policies.

26-6-108. Unearned premium reserve; increase of inadequate reserves.

If an insurer's loss experience shows or the commissioner determines that its loss reserves are inadequate, the insurer shall maintain loss reserves in an increased amount as is needed to make them adequate.

ARTICLE 2 - STANDARD VALUATION LAW POLICIES AND CONTRACTS

26-6-201. Short title; definitions.

(a) This article is known as the Standard Valuation Law.

(b) For the purposes of this article the following definitions shall apply on or after the operative date of the valuation manual. To the extent a definition which follows is inconsistent or different from a definition elsewhere in this code, the definition in this section shall be applicable for the purposes of this article:

(i) "Accident and health insurance" means contracts that incorporate morbidity risk and provide protection against economic loss resulting from accident, sickness or medical conditions and as may be specified in the valuation manual;

(ii) "Appointed actuary" means a qualified actuary who is appointed in accordance with the valuation manual to prepare the actuarial opinion required in W.S. 26-6-208(h);

(iii) "Deposit type contract" means contracts that do not incorporate mortality or morbidity risks and as may be specified in the valuation manual;

(iv) "Insurer" means an entity which:

(A) Has written, issued or reinsured life insurance contracts, accident and health insurance contracts or deposit type contracts in this state and has at least one (1) of the contracts or policies in force or on claim; or

(B) Has written, issued or reinsured life insurance contracts, accident and health insurance contracts or deposit type contracts in any state and is required to hold a certificate of authority to write life insurance, accident and health insurance or deposit type contracts in this state.

(v) "Life insurance" means contracts that incorporate mortality risk, including annuity and pure endowment contracts, and as may be specified in the valuation manual;

(vi) "Policyholder behavior" means any action a policyholder, contract holder or any other person with the right to elect options, such as a certificate holder, may take under a policy or contract subject to this article including lapse, withdrawal, transfer, deposit, premium payment, loan, annuitization or benefit elections prescribed by the policy or contract but excluding events of mortality or morbidity that

result in benefits prescribed in their essential aspects by the terms of the policy or contract;

(vii) "Principle based valuation" means a reserve valuation that uses one (1) or more methods or one (1) or more assumptions determined by the insurer and that complies with W.S. 26-6-210 as specified in the valuation manual;

(viii) Except as provided in W.S. 26-6-208(g), "qualified actuary" means an individual who is qualified to sign the applicable statement of actuarial opinion in accordance with the American Academy of Actuaries qualification standards for actuaries signing the statements and who meets the requirements specified in the valuation manual;

(ix) "Tail risk" means a risk that occurs where the frequency of low probability events is higher than expected under a normal probability distribution or where there are observed events of very significant size or magnitude;

(x) "Valuation manual" means the manual of valuation instructions adopted by the NAIC as specified in this article and as subsequently amended.

26-6-202. Annual valuation of reserves required; minimum standard valuation; other valuations accepted; conditions.

(a) Policies and contracts issued prior to the operative date of the valuation manual shall be governed by the following provisions:

(i) The commissioner, annually, shall value, or cause to be valued, the reserve liabilities (or reserves) for all outstanding life insurance policies and annuity and pure endowment contracts of any authorized life insurer issued prior to the operative date of the valuation manual. The commissioner may use group methods and approximate averages for fractions of a year or otherwise in calculating reserves. In the case of an alien insurer, the valuation is limited to its United States business;

(ii) Instead of the valuation of reserves required of any foreign or alien insurer, the commissioner may accept any valuation from the insurance supervisory official of any state or other jurisdiction if that valuation complies with the minimum standard provided in this article;

(iii) The commissioner may accept the valuation made by any domestic life insurer upon satisfactory proof of its correctness and compliance with W.S. 26-6-208;

(iv) The provisions set forth in W.S. 26-6-203 and 26-6-205 through 26-6-207 shall apply to all policies and contracts, as appropriate, subject to this article prior to the operative date of the valuation manual and the provisions set forth in W.S. 26-6-209 and 26-6-210 shall not apply to the policies and contracts.

(b) Repealed by Laws 2017, ch. 67, § 3.

(c) Any insurer which adopts any standard of valuation producing greater aggregate reserves than those calculated according to the minimum standard provided in this article, with the commissioner's approval, may adopt any lower standard of valuation, but not lower than the minimum standard. For the purposes of this section, the holding of additional reserves previously determined by the appointed actuary to be necessary to render the opinion required by W.S. 26-6-208 shall not be deemed to be the adoption of a higher standard of valuation.

(d) Reserves for any category of policies, contracts or benefits as the commissioner establishes, may at the insurer's option, be calculated according to any standards which produce greater aggregate reserves for the category than those calculated according to the minimum standard provided in this article. However, the rates of interest used for policies and contracts other than annuity and pure endowment contracts shall not be greater than the corresponding rates of interest used in calculating any nonforfeiture benefits provided in the policies and contracts.

(e) Policies and contracts issued on or after the operative date of the valuation manual shall be governed by the following provisions:

(i) The commissioner shall annually value, or cause to be valued, the reserve liabilities (or reserves) for all outstanding life insurance contracts, annuity and pure endowment contracts, accident and health contracts, and deposit type contracts of any authorized life insurer issued on or after the operative date of the valuation manual. In the case of an alien insurer, the valuation is limited to its United States business;

(ii) Instead of the valuation of reserves required of any foreign or alien insurer, the commissioner may accept any valuation from the insurance supervisory official of any state or other jurisdiction if that valuation complies with the minimum standard provided in this article;

(iii) The commissioner may accept the valuation made by any domestic life insurer upon satisfactory proof of its correctness and compliance with W.S. 26-6-208;

(iv) The provisions set forth in W.S. 26-6-209 and 26-6-210 shall apply to all policies and contracts issued on or after the operative date of the valuation manual.

26-6-203. Reserve calculation; valuation net premium exceeding gross premium charged.

(a) If in any contract year the gross premium charged by any insurer 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 for the policy or contract shall be the greater of either the reserve calculated according to:

(i) The mortality table, rate of interest and method actually used for the policy or contract; or

(ii) The method actually used for the policy or contract but using the minimum valuation standards of mortality and rate of interest and replacing the valuation net premium with 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 the standards stated in W.S. 26-6-205(b) and 26-6-206(b). However, for any life insurance policy issued on or after January 1, 1998 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 subsection shall be applied as if the method actually used in calculating the reserve for such policy were the method described in W.S. 26-6-205(c)(i). The minimum reserve at each policy anniversary of such a policy shall be the greater of the minimum reserve calculated in accordance with W.S.

26-6-205(c) and (d), and the minimum reserve calculated in accordance with this subsection.

26-6-204. Repealed by Laws 1994, ch. 76, § 3.

26-6-205. Computation of minimum standard; reserve valuation method, life insurance and endowment benefits; annuity and pure endowment benefits; minimum reserves; reserve calculation; indeterminate plans.

(a) Repealed by Laws 1994, ch. 76, § 3.

(b) Except as otherwise provided in W.S. 26-6-206 and 26-6-207 the minimum standard for the valuation of all policies and contracts subject to this article issued prior to the effective date of the standard valuation law shall be that provided by the laws in effect immediately prior to that date. Except as otherwise provided in W.S. 26-6-206 and 26-6-207 the minimum standard for the valuation of all policies and contracts subject to this article issued on or after the effective date of the standard valuation law and prior to the operative date of the valuation manual shall be the commissioners' reserve valuation method defined in subsections (c) and (e) of this section, W.S. 26-6-203 and 26-6-207, three and one-half percent (3 1/2%) interest or four percent (4%) interest for life insurance policies and contracts other than annuity and pure endowment contracts issued on or after July 1, 1975 and prior to May 20, 1981, five and one-half percent (5 1/2%) interest for single premium life insurance policies, and four and one-half percent (4 1/2%) interest for all other such policies issued on or after May 20, 1981, and the following tables:

(i) For ordinary policies of life insurance issued on the standard basis, excluding any disability and accidental death benefits in those policies:

(A) The commissioners' 1941 standard ordinary mortality table for such policies issued prior to the effective date of W.S. 26-16-208(a);

(B) The commissioners' 1958 standard ordinary mortality table for such policies issued on or after the effective date of W.S. 26-16-208(a) and prior to the operative date of W.S. 26-16-209, provided that for any category of such policies issued on female risks all modified net premiums and present values referred to in this subsection may be calculated

according to an age not more than six (6) years younger than the actual age of the insured; and

(C) For such policies issued on or after the operative date of W.S. 26-16-209:

(I) The commissioners' 1980 standard ordinary mortality table; or

(II) At the election of the company for any one (1) or more specified plans of life insurance, the commissioners' 1980 standard ordinary mortality table with ten (10) year select mortality factors; or

(III) Any ordinary mortality table adopted after 1980 by the National Association of Insurance Commissioners and approved by regulation the commissioner promulgates for use in determining the minimum standard of valuation for those policies.

(ii) For industrial life insurance policies issued on the standard basis, excluding any disability and accidental death benefits in those policies:

(A) The 1941 standard industrial life insurance policies for such policies issued prior to the effective date of W.S. 26-16-208(b);

(B) For such policies issued on or after the effective date of W.S. 26-16-208(b), the commissioners' 1961 standard industrial mortality table or any industrial mortality table adopted after 1980 by the National Association of Insurance Commissioners and approved by regulation the commissioner promulgates for use in determining the minimum standard of valuation for those policies.

(iii) For individual annuity and pure endowment contracts, excluding any disability and accidental death benefits in those policies, the 1937 standard annuity mortality table, or, at the insurer's option, the annuity mortality table for 1949, ultimate, or any modification of either of these tables the commissioner approves;

(iv) For group annuity and pure endowment contracts, excluding any disability and accidental death benefits in those policies, the group annuity mortality table for 1951, any modification of that table the commissioner approves, or, at the

insurer's option, any of the tables or modifications of tables specified for individual annuity and pure endowment contracts;

(v) For total and permanent disability benefits in or supplementary to ordinary policies or contracts, the following tables, provided any such table, for active lives, shall be combined with a mortality table permitted for calculating the reserves for life insurance policies:

(A) For policies or contracts issued on or after January 1, 1966, 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 table of disablement rates and termination rates the National Association of Insurance Commissioners adopts after 1980 and is approved by regulation the commissioner promulgates for use in determining the minimum standard of valuation for those policies;

(B) For policies or contracts issued on or after January 1, 1961 and prior to January 1, 1966, either such tables or, at the option of the company, the Class 3 Disability Table of 1926; and

(C) For policies issued prior to January 1, 1961, the Class 3 Disability Table of 1926.

(vi) For accidental death benefits in or supplementary to policies, the following tables, provided any table shall be combined with a mortality table for calculating the reserves for life insurance policies:

(A) For policies issued on or after January 1, 1966, the 1959 accidental death benefits table or any accidental death benefits table the National Association of Insurance Commissioners adopts after 1980 and is approved by regulation the commissioner promulgates for use in determining the minimum standard of valuation of those policies;

(B) For policies issued on or after January 1, 1961 and prior to January 1, 1966, either such table or, at the option of the company, the Inter-Company Double Indemnity Mortality Table;

(C) For policies issued prior to January 1, 1961, the Inter-Company Double Indemnity Mortality Table.

(vii) For group life insurance, life insurance issued on the substandard basis and other special benefits, any tables the commissioner approves.

(c) Except as provided in W.S. 26-6-203, 26-6-207 and subsection (e) of this section reserves according to the commissioners' reserve valuation method:

(i) 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 the future guaranteed benefits provided by those policies, over the then present value of any future modified net policy premiums. The modified net premiums for any such policy shall be a uniform percentage of the contract premiums for the benefits such that the present value, at the date of issue of the policy, of all the modified net premiums shall be equal to the sum of the then present value of the 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 the benefits provided after the first policy year, divided by the present value at the date of issue, of an annuity of one (1) per annum payable on each policy anniversary on which a premium falls due. The net level annual premium shall not exceed the net level annual premium on the nineteen (19) year premium whole life plan for insurance of the same amount at an age one (1) year higher than the age at issue of the policy; (2) A net one (1) year term premium for benefits provided in the first policy year;

(ii) For any life insurance policy issued on or after January 1, 1998 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 the excess and which provides an endowment benefit or a cash surrender value or a combination thereof in an amount greater than the 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 the excess premium, except as otherwise provided in W.S. 26-6-203, shall be the greater of the reserve as of the policy anniversary calculated as described in paragraph (i) of this subsection and the reserve as of the

policy anniversary calculated as described in that paragraph, but with:

(A) The value defined in subdivision (1) of paragraph (i) of this subsection being reduced by fifteen percent (15%) 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;

(D) The cash surrender value provided on such date being considered as an endowment benefit; and

(E) In making the comparison specified in this paragraph the mortality and interest bases stated in subsections (b) and (h) of this section shall be used.

(d) Reserves according to the commissioners' reserve valuation method for benefits provided by the following policies or contracts shall be calculated by a method consistent with the principles of subsection (c) of this section:

(i) Life insurance policies providing for a varying amount of insurance or requiring the payment of varying premiums;

(ii) Group annuity and pure endowment contracts purchased under a retirement or deferred compensation plan established or maintained by an employer, an employee organization or both, other than a plan providing individual retirement accounts or annuities under section 408 of the Internal Revenue Code;

(iii) Disability and accidental death benefits in all policies and contracts; and

(iv) All other benefits, except life insurance and endowment benefits in life insurance policies and benefits provided by other annuity and pure endowment contracts.

(e) This section applies to annuity and pure endowment contracts other than group annuity and pure endowment contracts purchased under a retirement or deferred compensation plan

established or maintained by an employer, including a partnership or sole proprietorship, an employee organization, or both, and other than a plan providing individual retirement accounts or annuities under section 408 of the Internal Revenue Code. Reserves according to the commissioners' annuity reserve method for benefits under annuity or pure endowment contracts, excluding disability and accidental death benefits in those contracts, shall be the greatest of the excesses of the present values, at the date of valuation, of any future guaranteed benefits, including guaranteed nonforfeiture benefits, provided by those contracts at the end of each 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 the contract that are payable prior to the end of the contract year. The future guaranteed benefits shall be determined by using the mortality table and the interest rates specified in the contracts for determining guaranteed benefits. The valuation considerations are the portions of the gross considerations applied under the contracts to determine nonforfeiture values.

(f) No insurer's aggregate reserves for all life insurance policies, excluding disability and accidental death benefits, shall be less than the aggregate reserves calculated in accordance with the method set forth in subsections (b), (c), (d), (e) and (h) of this section and W.S. 26-6-203, and the mortality tables and rates of interest used in calculating nonforfeiture benefits for those policies. In no event shall the aggregate reserves for all policies, contracts and benefits be less than the aggregate reserves determined by the appointed actuary to be necessary to render the opinion required by W.S. 26-6-208.

(g) Repealed by Laws 1994, ch. 76, § 3.

(h) For any plan of life insurance which provides that the amounts of future premiums will be determined by the insurance company based on the then estimates of future experience or which is of a nature that minimum reserves cannot be determined by the methods described in subsections (c), (d) and (e) of this section and W.S. 26-6-203, the commissioner shall promulgate regulations for determining the reserves so they are:

(i) Appropriate in relation to the benefits and the pattern of premiums for that plan; and

(ii) Computed by a method which is consistent with the principles of this article.

26-6-206. Computation of minimum standard for annuities; computation of minimum standard valuation by calendar year of issue.

(a) Except as provided in subsection (b) of this section the minimum standard of valuation for individual annuity and pure endowment contracts issued on or after the operative date of this section as defined in subsection (b) of this section, and for annuities and pure endowments purchased on or after that operative date under group annuity and pure endowment contracts, shall be the commissioners' reserve valuation method defined in W.S. 26-6-205(c), (d) and (e) and the following tables and interest rates:

(i) For individual annuity and pure endowment contracts issued:

(A) Prior to May 20, 1981, excluding any disability and accidental death benefits in those contracts, the 1971 individual annuity mortality table, or any modification of this table the commissioner approves, with six percent (6%) interest for single premium immediate annuity contracts and four percent (4%) interest for all other individual annuity and pure endowment contracts;

(B) On or after May 20, 1981, excluding any disability and accidental death benefits in those contracts, the 1971 individual annuity mortality table or any individual annuity mortality table the National Association of Insurance Commissioners adopts after 1980 and is approved by regulation the commissioner promulgates for use in determining the minimum standard of valuation for those contracts, or any modification of these tables the commissioner approves, and seven and one-half percent (7 1/2%) interest for single premium immediate annuity contracts, five and one-half percent (5 1/2%) interest for single premium deferred annuity and pure endowment contracts and four and one-half percent (4 1/2%) interest for all other individual annuity and pure endowment contracts.

(ii) For annuities and pure endowments purchased:

(A) Prior to May 20, 1981 under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under those contracts, the

1971 group annuity mortality table, or any modification of this table the commissioner approves, and six percent (6%) interest;

(B) On or after May 20, 1981 under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under those contracts, the 1971 group annuity mortality table or any group annuity mortality table the National Association of Insurance Commissioners adopts after 1980 and the commissioner approves for use in determining the minimum standard of valuation for those annuities and pure endowments, or any modification of these tables the commissioner approves, and seven and one-half percent (7 1/2%) interest.

(b)(i) The interest rates used in determining the minimum standard for the valuation of:

(A) Life insurance policies issued in a particular calendar year, on or after the operative date of W.S. 26-16-209;

(B) Individual annuity and pure endowment contracts issued in a particular calendar year on or after January 1, 1995;

(C) Annuities and pure endowments purchased in a particular calendar year on or after January 1, 1995, under group annuity and pure endowment contracts; and

(D) The net increase, if any, in a particular calendar year after January 1, 1995, in amounts held under guaranteed interest contracts shall be the calendar year statutory valuation interest rates as defined in this subsection.

(ii) The calendar year statutory valuation interest rates, I, shall be determined as follows and the results rounded to the nearer one-fourth percent (1/4%):

(A) For Life Insurance,

$$I = .03 + W (R1 - .03) + W (R2 - .09);$$

(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 R1 is the lesser of R and .09, R2 is the greater of R and .09, R is the reference interest rate defined in this subsection, and W is the weighting factor defined in this subsection;

(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 subparagraph (B) of this paragraph, the formula for life insurance stated in subparagraph (A) of this paragraph shall apply to annuities and guaranteed interest contracts with guarantee durations in excess of ten (10) years and the formula for single premium immediate annuities stated in subparagraph (B) of this paragraph shall apply to annuities and guaranteed interest contracts with guarantee duration of ten (10) 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 subparagraph (B) of this paragraph shall apply;

(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 subparagraph (B) of this paragraph shall apply.

(iii) 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 percent (1/2%), 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 W.S. 26-16-209 becomes operative;

(iv) The weighting factors referred to in the formulas stated above are given in the following tables:

(A) Weighting factors for life insurance:

GUARANTEE DURATION (YEARS)	WEIGHTING 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) 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:

.80

(C) Weighting factors for other annuities and for guaranteed interest contracts, except as stated in subparagraph (B) of this paragraph, shall be as specified in tables (I), (II) and (III) of this subparagraph, according to the rules and definitions in subdivisions (IV), (V) and (VI) of this subparagraph:

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

GUARANTEE DURATION	WEIGHTING FACTOR FOR PLAN TYPE

(YEARS)	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

(II) PLAN TYPE

	A	B	C
For annuities and guaranteed interest contracts valued on a change in fund basis, the factors shown in subdivision (I) of this subparagraph increased by:	.15	.25	.05

(III) PLAN TYPE

	A	B	C
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 (1) 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 (12) months beyond the valuation

date, the factors shown in subdivision (I)

of this subparagraph or derived in

subdivision (II) of this subparagraph

increased by: .05 .05 .05

(IV) 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 (20) 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;

(V) Plan type as used in the tables in this subparagraph is defined as follows:

Plan Type A: At any time 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, or (2) without such adjustment but in installments over five (5) years or more, or (3) as an immediate life annuity, or (4) no withdrawal permitted.

Plan Type B: Before expiration of the interest rate guarantee, policyholder may withdraw funds only (1) with an adjustment to reflect changes in interest rates or assets values since receipt of the funds by the insurance company, or (2) without such adjustment but in installments over five (5) 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 (5) years.

Plan Type C: Policyholder may withdraw funds before expiration of interest rate guarantee in a single sum or installments over less than five (5) years either without adjustment to reflect changes in interest rates or asset values since receipt of the

funds by the insurance company, or subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund.

(VI) 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 subsection, 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.

(v) The reference interest rate referred to in paragraphs (ii) and (iii) of this subsection shall be defined as follows:

(A) For life insurance, the lesser of the average over a period of thirty-six (36) months and the average over a period of twelve (12) months, ending on June 30 of the calendar year next preceding the year of issue, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.;

(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 (12) months, ending on June 30 of the calendar year of issue or year of purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.;

(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 subparagraph (B) of this paragraph, with guarantee duration in

excess of ten (10) years, the lesser of the average over a period of thirty-six (36) months and the average over a period of twelve (12) months, ending on June 30 of the calendar year of issue or purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.;

(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 subparagraph (B) of this paragraph, with guarantee duration of ten (10) years or less, the average over a period of twelve (12) months, ending on June 30 of the calendar year of issue or purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.;

(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 (12) months, ending on June 30 of the calendar year of issue or purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.;

(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 subparagraph (B) of this paragraph, the average over a period of twelve (12) months, ending on June 30 of the calendar year of the change in the fund, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.

(vi) If the monthly average of the composite yield on seasoned corporate bonds is no longer published by Moody's Investor's Service, Inc., or if the National Association of Insurance Commissioners determines that the monthly average of the composite yield on seasoned corporate bonds as published by Moody's Investors Service, Inc. 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 regulation promulgated by the commissioner, may be substituted.

(c) Any insurer may file with the commissioner a written notice of its election to comply with this section after a specified date before January 1, 1979, which is the operative date of this section for that insurer. An insurer may elect a different operative date for individual annuity and pure endowment contracts from that elected for group annuity and pure endowment contracts. If an insurer makes no election, the operative date of this section for that insurer is January 1, 1979.

26-6-207. Minimum standards for accident and health insurance contracts including disability plans.

The commissioner shall promulgate regulations containing the minimum standards applicable to the valuation of accident and health contracts, including disability plans, issued prior to the operative date of the valuation manual. For accident and health insurance contracts issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under W.S. 26-6-202(e).

26-6-208. Actuarial opinion of reserves.

(a) Repealed by Laws 2017, ch. 67, § 3.

(b) Repealed by Laws 2017, ch. 67, § 3.

(c) Repealed by Laws 2017, ch. 67, § 3.

(d) Repealed by Laws 2017, ch. 67, § 3.

(e) Repealed by Laws 2017, ch. 67, § 3.

(f) Repealed by Laws 2017, ch. 67, § 3.

(g) Actuarial opinions issued prior to the operative date of the valuation manual shall be governed by the following provisions:

(i) Every life insurer doing business in this state shall annually submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by regulation are computed appropriately, are based on assumptions which satisfy contractual provisions, are consistent with prior reported amounts and comply with applicable laws of this state.

The commissioner by regulation shall define the specifics of this opinion and add any other items deemed to be necessary to its scope;

(ii) Every life insurer, except as exempted by regulation, shall also annually include in the opinion required by paragraph (i) of this subsection, an opinion of the same qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by regulation, when considered in light of the assets held by the insurer with respect to the reserves and related actuarial items, including the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the insurer's obligations under the policies and contracts including the benefits under and expenses associated with the policies and contracts. The commissioner may provide by regulation for a transition period for establishing any higher reserves which the qualified actuary deems necessary in order to render the opinion required by this section;

(iii) Each opinion required by paragraph (ii) of this subsection shall be governed by the following provisions:

(A) A memorandum, in form and substance acceptable to the commissioner as specified by regulation, shall be prepared to support each actuarial opinion;

(B) If the insurer fails to provide a supporting memorandum at the request of the commissioner within a period specified by regulation or the commissioner determines that the supporting memorandum provided by the insurer fails to meet the standards prescribed by regulation or is unacceptable to the commissioner, the commissioner may engage a qualified actuary at the expense of the insurer to review the opinion and the basis for the opinion and prepare any supporting memorandum required by the commissioner.

(iv) Every opinion required by this subsection shall be governed by the following provisions:

(A) The opinion shall be submitted with the annual statement reflecting the valuation of reserve liabilities for each year ending on or after December 31, 1995;

(B) The opinion shall apply to all business in force including individual and group health insurance plans, in

form and substance acceptable to the commissioner as specified by regulation;

(C) The opinion shall be based on standards adopted by the actuarial standards board and on additional standards as the commissioner by regulation prescribes;

(D) In the case of an opinion required to be submitted by a foreign or alien insurer, the commissioner may accept the opinion filed by that insurer with the insurance supervisory official of another state if the commissioner determines that the opinion reasonably meets the requirements applicable to an insurer domiciled in this state;

(E) Except in cases of fraud, willful misconduct or negligence the qualified actuary shall not be liable for damages to any person, other than the insurer and the commissioner, for any act, error, omission, decision or conduct with respect to the actuary's opinion;

(F) Disciplinary action by the commissioner against the insurer or the qualified actuary shall be in accordance with W.S. 26-1-107;

(G) Any memorandum in support of the opinion, and any other material provided by the insurer to the commissioner in connection with the opinion, shall be kept confidential by the commissioner, may be shared as authorized by and in accordance with the provisions of W.S. 26-2-113(d), and shall not be made public other than for the purpose of defending an action seeking damages from any person by reason of any action required by this section or by regulations promulgated under this section. Once any portion of the confidential memorandum is cited by the insurer in its marketing or is cited before any governmental agency other than a state insurance department or is released by the insurer to the news media, no portion of the memorandum shall be confidential. The memorandum or other material may otherwise be released by the commissioner:

(I) With the written consent of the insurer; or

(II) To the American Academy of Actuaries upon request stating that the memorandum or other material is required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the

commissioner for preserving the confidentiality of the memorandum or other material.

(v) For the purposes of this subsection, "qualified actuary" means a member in good standing of the American Academy of Actuaries and who meets requirements prescribed by regulation of the commissioner.

(h) Actuarial opinions of reserves issued after the operative date of the valuation manual shall be governed by the following provisions:

(i) Every insurer with outstanding life insurance contracts, accident and health insurance contracts or deposit type contracts in this state and subject to regulation by the commissioner shall annually submit the opinion of the appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts are computed appropriately, based on assumptions that satisfy contractual provisions, consistent with prior reported amounts and comply with applicable laws of this state;

(ii) Every insurer with outstanding life insurance contracts, accident and health insurance contracts or deposit type contracts in this state and subject to regulation by the commissioner, except as exempted in the valuation manual, shall also annually include in the opinion required by paragraph (i) of this subsection, an opinion of the same appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified in the valuation manual, when considered in light of the assets held by the insurer with respect to the reserves and related actuarial items including the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the insurer's obligations under the policies and contracts including the benefits under and expenses associated with the policies and contracts;

(iii) Each opinion required by paragraph (ii) of this subsection shall be governed by the following provisions:

(A) A memorandum, in form and substance as specified in the valuation manual and acceptable to the commissioner, shall be prepared to support each actuarial opinion;

(B) If the insurer fails to provide a supporting memorandum at the request of the commissioner within a period specified in the valuation manual or the commissioner determines that the supporting memorandum provided by the insurer fails to meet the standards prescribed by the valuation manual or is otherwise unacceptable to the commissioner, the commissioner may engage a qualified actuary at the expense of the insurer to review the opinion and the basis for the opinion and prepare the supporting memorandum required by the commissioner.

(iv) Every opinion required by this subsection shall be governed by the following provisions:

(A) The opinion shall be in form and substance as specified in the valuation manual and acceptable to the commissioner;

(B) The opinion shall be submitted with the annual statement reflecting the valuation of such reserve liabilities for each year ending on or after the operative date of the valuation manual;

(C) The opinion shall apply to all policies and contracts subject to paragraph (ii) of this subsection, plus other actuarial liabilities as may be specified in the valuation manual;

(D) The opinion shall be based on standards adopted by the actuarial standards board or its successor, and on any additional standards as may be prescribed in the valuation manual;

(E) In the case of an opinion required to be submitted by a foreign or alien insurer, the commissioner may accept the opinion filed by that insurer with the insurance supervisory official of another state if the commissioner determines that the opinion reasonably meets the requirements applicable to an insurer domiciled in this state;

(F) Except in cases of fraud or willful misconduct, the appointed actuary shall not be liable for damages to any person, other than the insurer and the commissioner, for any act, error, omission, decision or conduct with respect to the appointed actuary's opinion;

(G) Disciplinary action by the commissioner against the insurer or the appointed actuary shall be in accordance with W.S. 26-1-107.

26-6-209. Valuation manual for policies and contracts; amendments to manual; rules on minimum valuation standards; actuarial examinations.

(a) For policies or contracts issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under W.S. 26-6-202(e), except as provided under subsection (e) or (g) of this section.

(b) The operative date of the valuation manual is January 1, 2017.

(c) Unless an amendment in the valuation manual specifies a later effective date, amendments to the valuation manual shall be effective on January 1 following the date when all of the following have occurred:

(i) The change to the valuation manual has been adopted by the NAIC by an affirmative vote representing:

(A) At least three-fourths (3/4) of the members of the NAIC voting, but not less than a majority of the total membership; and

(B) Members of the NAIC representing jurisdictions totaling greater than seventy-five percent (75%) of the direct premiums written as reported in the following annual statements most recently available prior to the vote in subparagraph (A) of this paragraph:

(I) Life, accident and health annual statements;

(II) Health annual statements; or

(III) Fraternal annual statements.

(d) The valuation manual shall specify all of the following:

(i) Minimum valuation standards for and definitions of the policies or contracts subject to W.S. 26-6-202(e). The minimum valuation standards shall be:

(A) The commissioner's reserve valuation method for life insurance contracts, other than annuity contracts, subject to W.S. 26-6-202(e);

(B) The commissioner's reserve valuation method for annuity contracts subject to W.S. 26-6-202(e); and

(C) Minimum reserves for all other policies or contracts subject to W.S. 26-6-202(e).

(ii) Which policies or contracts or types thereof are subject to the requirements of a principle based valuation under W.S. 26-6-210(a) and the minimum valuation standards consistent with those requirements;

(iii) For policies and contracts subject to a principle based valuation under W.S. 26-6-210:

(A) Requirements for the format of reports to the commissioner under W.S. 26-6-210(b)(iii), which shall include information necessary to determine if the valuation is appropriate and in compliance with this article;

(B) Assumptions for risks over which the insurer does not have significant control or influence;

(C) Procedures for corporate governance and actuarial function oversight and a process for appropriate waiver or modification of the procedures.

(iv) For policies and contracts not subject to a principle based valuation under W.S. 26-6-210, the minimum valuation standard shall either:

(A) Be consistent with the minimum standard of valuation prior to the operative date of the valuation manual; or

(B) Require reserves that quantify the benefits, guarantees, funding and risks associated with the policies or contracts at a level of conservatism that reflects conditions including unfavorable events with a reasonable probability of occurring.

(v) The experience data required under W.S. 26-6-211 including reporting and any data analysis requirements; and

(vi) Any other requirement including those relating to reserve methods, models for measuring risk, generation of economic scenarios, assumptions, margins, use of company experience, risk measurement, disclosure, certifications, reports, actuarial opinions and memoranda, transition rules and internal controls.

(e) In the absence of a specific valuation requirement or if a specific valuation requirement in the valuation manual is not in the commissioner's opinion in compliance with this article, the insurer shall comply with minimum valuation standards prescribed by the commissioner by rule or regulation.

(f) The commissioner may, at the expense of the insurer, engage, employ or contract a qualified actuary to perform an actuarial examination of the insurer and opine on the appropriateness of any reserve assumption or method used by the insurer, or to review and opine on an insurer's compliance with any requirement set forth in this article. The commissioner may rely upon the opinion of a qualified actuary engaged by the commissioner of another state, district or territory of the United States regarding provisions contained within this article.

(g) The commissioner may require an insurer to change any assumption or method that in the commissioner's opinion is necessary to comply with the requirements of the valuation manual or this article. An insurer shall adjust the reserves as required by the commissioner. The commissioner may take other disciplinary action as permitted pursuant to W.S. 26-1-107.

26-6-210. Principle based valuation; requirements.

(a) An insurer shall establish reserves using a principle based valuation that meets all of the following conditions for policies or contracts issued on or after the operative date of the valuation manual as specified in the valuation manual:

(i) Quantifies the benefits, guarantees, funding and risks associated with the policies or contracts at a level of conservatism that reflects conditions including unfavorable events with a reasonable probability of occurring during the lifetime of the contracts. For policies or contracts with

significant tail risk, reflects conditions appropriately adverse to quantify the tail risk;

(ii) Incorporates assumptions, risk analysis methods and financial models and management techniques that are consistent with those utilized within the insurer's overall risk assessment process, while recognizing potential differences in financial reporting structures and any prescribed assumptions or methods;

(iii) Incorporates assumptions derived in one (1) of the following manners:

(A) Assumptions prescribed in the valuation manual;

(B) For assumptions not prescribed in the valuation manual, assumptions that:

(I) Use the insurer's available experience, to the extent it is relevant and statistically credible; or

(II) To the extent that company data on experience is not available, relevant or statistically credible, use other relevant, statistically credible experience.

(iv) Provides margins for uncertainty including adverse deviation and estimation error such that the greater the uncertainty the greater the margin and resulting reserve.

(b) An insurer using a principle based valuation for one (1) or more policies or contracts subject to this section as specified in the valuation manual shall:

(i) Establish procedures for corporate governance and oversight of the actuarial valuation function consistent with those described in the valuation manual;

(ii) Provide to the commissioner and the insurer's board of directors an annual certification of the effectiveness of the internal controls with respect to the principle based valuation. The controls shall be designed to assure all material risks inherent in the liabilities and associated assets subject to the valuation are included in the valuation and valuations are made in accordance with the valuation manual. The certification shall be based on the controls in place as of the end of the preceding calendar year;

(iii) Develop, and file with the commissioner upon the commissioner's request, a principle based valuation report that complies with standards prescribed in the valuation manual.

(c) A principle based valuation may include a prescribed formulaic reserve component.

26-6-211. Experience data reporting for policies and contracts.

An insurer shall submit mortality, morbidity, policyholder behavior or expense experience and other data as prescribed in the valuation manual.

26-6-212. Confidential information; when disclosure is permitted.

(a) Privilege for, and confidentiality of, confidential information is as follows:

(i) Except as otherwise provided in this section, an insurer's confidential information is confidential and privileged and shall not be subject to public inspection, subpoena, discovery or be admissible in evidence in any private civil action. The commissioner may use an insurer's confidential information in the furtherance of any regulatory or legal action brought against the insurer as part of the commissioner's official duties;

(ii) Neither the commissioner nor any person who receives confidential information while acting under the authority of the commissioner shall be permitted or required to testify in any private civil action concerning an insurer's confidential information;

(iii) In order to assist in the performance of the commissioner's duties, and provided that a recipient agrees, and has the legal authority to agree to maintain the confidentiality and privileged status of documents, materials, data and other information in the same manner and to the same extent as required for the commissioner, the commissioner may share confidential information with other state, federal and international regulatory agencies or law enforcement officials, with the NAIC and its affiliates and subsidiaries and, in the case of confidential information specified in paragraphs (c)(i) and (iv) of this section only, with the actuarial board for

counseling and discipline or its successor upon request stating that the confidential information is required for the purpose of professional disciplinary proceedings and with state, federal and international law enforcement officials;

(iv) The commissioner may receive documents, materials, data and other information, including otherwise confidential and privileged documents, materials, data or information, from the NAIC and its affiliates and subsidiaries, regulatory or law enforcement officials of other foreign or domestic jurisdictions and the actuarial board for counseling and discipline or its successor. The commissioner shall maintain as confidential or privileged any document, material, data or other information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or other information;

(v) The commissioner may enter into agreements governing the sharing and use of information consistent with the provisions of this subsection;

(vi) No waiver of any applicable privilege or claim of confidentiality in the confidential information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized under paragraph (iii) of this subsection;

(vii) A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this subsection shall be available and enforced in any proceeding of this state;

(viii) As used in this section "regulatory agency," "law enforcement agency" and the "NAIC" include their employees, agents, consultants and contractors.

(b) Notwithstanding subsection (a) of this section, any confidential information specified in paragraphs (c)(i) and (iv) of this section:

(i) May be subject to subpoena for the purpose of defending an action seeking damages from the appointed actuary submitting the related memorandum in support of an opinion submitted under W.S. 26-6-208 or principle based valuation report developed under W.S. 26-6-210(b)(iii) by reason of an

action required by this article or by rule or regulation promulgated in accordance with this article;

(ii) May otherwise be released by the commissioner with the written consent of the insurer the confidential information relates to; and

(iii) Once any portion of a memorandum in support of an opinion submitted under W.S. 26-6-208 or a principle based valuation report developed under W.S. 26-6-210(b)(iii) is cited by the insurer in its marketing or is publicly volunteered to or before a governmental agency other than a state insurance department or is released by the insurer to the news media, all portions of the memorandum or report shall no longer be privileged or confidential.

(c) For purposes of this section, "confidential information" means:

(i) A memorandum in support of an opinion submitted under W.S. 26-6-208 and any other documents, materials and other information including all working papers, and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in connection with the memorandum;

(ii) Except as otherwise provided in this paragraph, all documents, materials, digital or electronic documents and other information including all working papers, and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in the course of an examination made under W.S. 26-6-209(f). If an examination report or other material prepared in connection with an examination made under W.S. 26-2-116 is not held as private and confidential information under W.S. 26-2-116, an examination report or other material prepared in connection with an examination made under W.S. 26-6-209(f) shall not be confidential information to the same extent as if the examination report or other material had been prepared under W.S. 26-2-116;

(iii) Any reports, documents, materials and other information developed by an insurer in support of, or in connection with, an annual certification by the insurer under W.S. 26-6-210(b)(ii) and any reports, documents, materials, digital or electronic documents and other information including all working papers, and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person

in connection with the reports, documents, materials and other information;

(iv) Any principle based valuation report developed under W.S. 26-6-210(b)(iii) and any other documents, materials, digital or electronic documents and other information including all working papers, and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in connection with the report; and

(v) Any experience data submitted by an insurer under W.S. 26-6-211 and any reports, documents, materials, data, digital or electronic documents and other information including all working papers, and copies thereof, created or produced in connection with the experience data that include any potentially insurer identifying or personally identifiable information, that is provided to or obtained by the commissioner. This includes any reports, documents, materials, data, digital or electronic documents and other information including all working papers, and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in connection with the experience data or any other report, document, material, datum, digital or electronic documents or other information referred to in this paragraph.

26-6-213. Single state exemption.

(a) The commissioner may exempt specific product forms or product lines of a domestic insurer that is licensed and doing business only in Wyoming from the requirements of W.S. 26-6-209, provided that:

(i) The commissioner has issued an exemption in writing to the insurer and has not subsequently revoked the exemption in writing; and

(ii) The insurer computes reserves using assumptions and methods used prior to the operative date of the valuation manual in addition to any requirements established by rule and regulation of the commissioner.

(b) For any insurer granted an exemption under this section, W.S. 26-6-203 and 26-6-205 through 26-6-208 shall be applicable. With respect to any insurer applying the exemption granted under this section, any reference to W.S. 26-6-209 found in W.S. 26-6-203 and 26-6-205 through 26-6-208 shall not be applicable.

ARTICLE 3 - VALUATION OF OTHER SECURITIES

26-6-301. Valuation of bonds and other debt securities.

(a) The commissioner may, by rule or regulation, require that any bond or other evidence of debt held by an insurer be valued in accordance with the most recent published valuation standards of the National Association of Insurance Commissioners. Any bonds or other evidences of debt as to which the National Association of Insurance Commissioners has not published valuation standards in its valuations of securities manual, if amply secured and not in default as to principal or interest, shall be valued as follows:

(i) If purchased at par, at the par value;

(ii) 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, or instead of this method, according to an accepted method of valuation the commissioner approves;

(iii) Purchase price shall in no case be taken at a higher figure than the actual fair value at the time of acquisition regardless of how acquired, plus actual brokerage, transfer, postage or express charges paid in the acquisition of the securities;

(iv) Unless otherwise provided by valuation the commissioner establishes or approves, no such security shall be carried at above the call price for the entire issue during any period within which the security may be called.

(b) The commissioner has full discretion in determining the method of calculating values according to the rules set forth in this section.

26-6-302. Valuation of other securities.

(a) The commissioner may, by rule or regulation, require that securities other than securities referred to in W.S. 26-6-301 and except as provided in W.S. 26-16-502(a)(iv), held by an insurer, be valued in accordance with the most recent published valuation standards of the National Association of Insurance Commissioners. At the commissioner's discretion,

securities as to which the National Association of Insurance Commissioners has not published valuation standards shall be valued at their fair value, or at their appraised value or at prices the commissioner determines as representing their fair value.

(b) Preferred or guaranteed stocks or shares while paying full dividends may be carried at a fixed value instead of fair value at the commissioner's discretion and in accordance with a method of computation he approves.

(c) The stock of an insurer's subsidiary shall be valued on the basis of the value of only those assets of the subsidiary as would constitute lawful investments of the insurer if acquired or held directly by the insurer.

26-6-303. Valuation of real and personal property.

(a) All real property shall be valued as set forth in the most recent National Association of Insurance Commissioners' accounting practices and procedures manual.

(i) Repealed by Laws 1994, ch. 76, § 3.

(ii) Repealed by Laws 1994, ch. 76, § 3.

(iii) Repealed by Laws 1994, ch. 76, § 3.

(iv) Repealed By Laws 2001, Ch. 9, § 2.

(v) Repealed By Laws 2001, Ch. 9, § 2.

(b) Repealed by Laws 1994, ch. 76, § 3.

(c) Personal property acquired pursuant to loans on the security of chattels made in accordance with W.S. 26-7-111 shall not be valued at an amount greater than the unpaid balance of principal on the defaulted loan at the date of acquisition together with taxes and expenses incurred in connection with the acquisition, or the fair value of the property, whichever is less.

26-6-304. Valuation of purchase money mortgages.

Purchase money mortgages on real property shall be valued in accordance with the most recent National Association of

Insurance Commissioners' accounting practices and procedures manual.

26-6-305. "Insolvency" and "impairment" defined.

(a) An insurer is insolvent if its total assets, as in this chapter provided, are less than its total liabilities, excluding as a liability, as to a stock insurer, the aggregate par value of its outstanding capital stock.

(b) An insurer is impaired if:

(i) As to a stock insurer, the sum of its assets is less than the sum of:

(A) Its liabilities;

(B) The aggregate par value of its outstanding capital stock; and

(C) The amount of surplus the insurer is required to maintain for the kinds of insurance transacted.

(ii) As to a mutual or reciprocal insurer, the sum of its assets is less than the sum of its liabilities and the amount of surplus the insurer is required to maintain for the kinds of insurance transacted.

ARTICLE 4 - PROPERTY AND CASUALTY ACTUARIAL OPINIONS

26-6-401. Short title; effective date.

This article shall be known as the property and casualty actuarial opinion law. W.S. 26-6-402 and 26-6-403 shall be effective beginning January 1, 2008 and shall be applicable to filings submitted after January 1, 2009.

26-6-402. Actuarial opinion of reserves and supporting documentation.

(a) Every property and casualty insurance company doing business in this state, unless otherwise exempted by the domiciliary commissioner, shall annually submit the opinion of an appointed actuary entitled "statement of actuarial opinion." This opinion shall be filed in accordance with the appropriate National Association of Insurance Commissioners property and casualty annual statement instructions.

(b) Every property and casualty insurance company domiciled in this state that is required to submit a statement of actuarial opinion shall annually submit an actuarial opinion summary, written by the company's appointed actuary. This actuarial opinion summary shall be filed in accordance with the appropriate National Association of Insurance Commissioners property and casualty annual statement instructions and shall be considered as a document supporting the actuarial opinion required in subsection (a) of this section. A company licensed but not domiciled in this state shall provide the actuarial opinion summary upon request.

(c) An actuarial report and underlying workpapers as required by the appropriate National Association of Insurance Commissioners property and casualty annual statement instructions shall be prepared to support each actuarial opinion required under this article. If the insurance company fails to provide a supporting actuarial report or workpapers at the request of the commissioner or the commissioner determines that the supporting actuarial report or workpapers provided by the insurance company is otherwise unacceptable to the commissioner, the commissioner may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare the supporting actuarial report or workpapers.

(d) The appointed actuary shall not be liable for damages to any person, other than the insurance company and the commissioner, for any act, error, omission, decision or conduct with respect to the actuary's opinion, except in cases of fraud or willful misconduct on the part of the appointed actuary.

26-6-403. Confidentiality.

(a) The statement of actuarial opinion required under W.S. 26-6-402 shall be provided with the annual statement in accordance with National Association of Insurance Commissioners property and casualty annual statement instructions and shall be treated as a public document.

(b) Documents, materials or other information in the possession or control of the department that are considered an actuarial report, workpapers or actuarial opinion summary provided in support of the opinion, and any other material provided by the company to the commissioner in connection with the actuarial report, workpapers or actuarial opinion summary,

shall be confidential by law and privileged, shall not be subject to inspection under W.S. 16-4-201 through 16-4-205, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. This provision shall not be construed to limit the commissioner's authority to release the documents to the actuarial board for counseling and discipline established by the American academy of actuaries so long as the material is required for the purpose of professional disciplinary proceedings and that the actuarial board for counseling and discipline establishes procedures satisfactory to the commissioner for preserving the confidentiality of the documents. Nor shall this section be construed to limit the commissioner's authority to use the documents, materials or other information in furtherance of any regulatory or legal action brought as part of the commissioner's official duties.

(c) Neither the commissioner nor any person who received documents, materials or other information while acting under the authority of the commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials or information subject to subsection (b) of this section.

(d) In order to assist in the performance of the commissioner's duties, the commissioner may:

(i) Share documents, materials or other information, including the confidential and privileged documents, materials or information subject to subsection (b) of this section with other state, federal and international regulatory agencies, with the National Association of Insurance Commissioners and its affiliates and subsidiaries, and with state, federal and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material or other information and has the legal authority to maintain confidentiality;

(ii) Receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the National Association of Insurance Commissioners and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or

privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(iii) Enter into agreements governing sharing and use of information consistent with this section.

(e) No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in subsection (d) of this section.

CHAPTER 7 - INVESTMENTS

26-7-101. Scope of chapter.

Except as to W.S. 26-7-116, this chapter applies to domestic insurers only.

26-7-102. Definitions of terms used in chapter; determination of net earnings.

(a) As used in this chapter:

(i) "Fixed charges" means interest on funded and unfunded debt amortization of debt discount and rentals for leased properties;

(ii) "Institution" means corporations, joint-stock associations and business trusts;

(iii) "Net earnings available for fixed charges" means net income after deducting operating and maintenance expenses, taxes, other than federal and state income taxes, depreciation and depletion, but excluding extraordinary nonrecurring items of income or expense appearing in the regular financial statements of the institutions involved;

(iv) "Obligations" means bonds, debentures, notes or other evidences of indebtedness;

(v) "Domestic jurisdiction" means the United States and Canada and includes any state, province or political subdivision of the United States or Canada;

(vi) "Foreign jurisdiction" means a jurisdiction other than a domestic jurisdiction;

(vii) "Foreign investment" means an investment in a foreign jurisdiction, or an investment in a person, real estate or asset domiciled in a foreign jurisdiction. Each of the following apply to this paragraph:

(A) An investment shall not be deemed to be foreign if the issuing person, qualified primary credit source or qualified guarantor is a domestic jurisdiction or a person domiciled in a domestic jurisdiction, unless:

(I) The issuing person is a shell business entity; and

(II) The investment is not assumed, accepted, guaranteed or insured or otherwise backed by a domestic jurisdiction or a person, that is not a shell business entity, domiciled in a domestic jurisdiction.

(B) For purposes of this paragraph:

(I) "Qualified guarantor" means a guarantor against which an insurer has a direct claim for full and timely payment, evidenced by a contractual right for which an enforcement action can be brought in a domestic jurisdiction;

(II) "Qualified primary credit source" means the credit source to which an insurer looks for payment as to an investment and against which an insurer has a direct claim for full and timely payment, evidenced by a contractual right for which an enforcement action can be brought in a domestic jurisdiction;

(III) "Shell business entity" means a business entity having no economic substance except as a vehicle for owning interests in assets issued, owned or previously owned by a person domiciled in a foreign jurisdiction.

(viii) "High grade investment" means a credit instrument rated one (1) or two (2) by the securities valuation office;

(ix) "Securities valuation office" means the securities valuation office of the National Association of Insurance Commissioners, or any successor office established by the National Association of Insurance Commissioners.

(b) If net earnings are determined in reliance upon consolidated earnings statements of parent and subsidiary institutions, those net earnings shall be determined after provision for income taxes of subsidiaries and after proper allowance for minority stock interest if any. The required coverage of fixed charges shall be computed on a basis including fixed charges and preferred dividends of subsidiaries other than those payable by the subsidiaries to the parent corporation or to any other of the subsidiaries, except that if the minority common stock interest in the subsidiary corporation is substantial, the fixed charges and preferred dividends may be apportioned in accordance with regulations the commissioner prescribes.

26-7-103. Eligible investments.

(a) Insurers shall invest in or lend their funds on the security of and shall hold as invested assets only eligible investments prescribed in this chapter.

(b) Any particular investment held by an insurer on January 1, 1968, which was a legal investment at the time it was made, and which the insurer was legally entitled to possess immediately prior to that date, is an eligible investment.

(c) Eligibility of an investment is determined as of the date of its making or acquisition, except as stated in subsection (b) of this section.

(d) Any investment limitation based upon the amount of the insurer's assets or particular funds relates to those assets or funds as shown by the insurer's annual statement as of December 31 immediately preceding the date of the insurer's acquisition of the investment, or as shown by a current financial statement resulting from merger of another insurer, bulk reinsurance or change in capitalization.

(e) An insurer authorized to transact insurance in a foreign jurisdiction may make investments, in aggregate amount not exceeding its deposit and reserve obligations incurred in that foreign jurisdiction, in securities of or in that foreign jurisdiction possessing characteristics and of a quality similar to like investments in the United States.

26-7-104. General qualifications for investments.

(a) No security or investment, other than property acquired under W.S. 26-7-107(a)(xiii), is eligible for acquisition unless it is interest bearing or interest accruing or dividend or income paying, is not then in default and the insurer is entitled to receive for its exclusive account and benefit the interest or income accruing thereon. Any stock or digital security as defined by W.S. 34-29-101(a)(iii) which has the ability to appreciate in value shall be considered to be income paying for purposes of this subsection.

(b) No security or investment is eligible for purchase at a price above its market value.

(c) Nothing in this chapter prohibits an insurer from acquiring other or additional securities or property if received as a dividend or as a lawful distribution of assets, or under a lawful and bona fide agreement of bulk reinsurance, merger or consolidation. Any investment so acquired which is not otherwise eligible under this chapter shall be disposed of pursuant to W.S. 26-7-112 if real property, or pursuant to W.S. 26-7-113 if personal property or securities.

26-7-105. Investment authorization; record.

(a) No insurer shall make any investment or loan, other than a policy loan or an annuity contract loan of a life insurer, unless the investment or loan is authorized by the insurer's board of directors or by a committee authorized by the board and charged with the supervision or making of the investment or loan. The minutes of any such committee shall be recorded and regular reports of the committee shall be submitted to the board of directors.

(b) The insurer shall maintain a full record of each investment, showing, among other pertinent information, the name of any officer, director or principal stockholder of the insurer having any interest in the securities, loan or property constituting the investment, or in the person in whose behalf the investment is made, and the nature of the interest.

26-7-106. Diversification of and limits on investments.

(a) An insurer shall invest in or hold as admitted assets only categories of investments within applicable limits as follows:

(i) No insurer shall have at any time any combination of investments in or loans upon the security of the obligations, property or securities of any one (1) person, institution, corporation or municipal corporation aggregating an amount exceeding five percent (5%) of the insurer's admitted assets, except this does not apply to general obligations of the United States of America or of any state and shall not include policy loans made under W.S. 26-7-108 or mutual funds that are registered with the federal securities and exchange commission and are diversified within the meaning of the Investment Company Act of 1940 as from time to time amended. Investments in diversified mutual funds shall be limited to ten percent (10%) of the insurer's admitted assets per fund;

(ii) No insurer shall invest in or hold at any time more than ten percent (10%) of the outstanding voting stock of any corporation, except with respect to voting rights of preference stock during default of dividends, except this does not apply to stock of an insurer's subsidiary acquired under W.S. 26-7-107(a)(vii) or (xiv), or to controlling stock of an insurer acquired under W.S. 26-7-107(a)(vi);

(iii) An insurer, other than a title insurer, shall invest and maintain invested funds not less in amount than the minimum paid-in capital stock required under this code of a domestic stock insurer transacting like kinds of insurance, only in cash and the securities provided under W.S. 26-7-107(a)(i) and 26-7-107(a)(xii);

(iv) A life insurer shall also invest and keep invested its funds, in an amount not less than the reserves under its life insurance policies and annuity contracts in force, in cash or the securities or investments allowed under this chapter, other than in common stocks, insurance stocks and stocks of the insurer's subsidiaries;

(v) No life insurer shall invest and have invested at any time in aggregate amount more than seven percent (7%) of its assets in all stocks under W.S. 26-7-107(a)(iv), (v), (vi) and (viii), except this does not apply to stock of a controlled or subsidiary corporation under W.S. 26-7-107(a)(vi), (vii) and (xiv);

(vi) No insurer shall have invested at any time more than sixty-five percent (65%) of its assets in obligations secured by mortgage, trust deed, contract of purchase or other similar encumbrance of real property;

(vii) No insurer shall have invested at any time more than seven percent (7%) of its assets in either improvement district obligations or equipment trust certificates;

(viii) Investments in real property are limited as provided in W.S. 26-7-107(a)(xiii); and

(ix) Other specific limits apply as stated in the sections dealing with other kinds of investments.

26-7-107. Authorized investments.

(a) An insurer may invest in:

(i) Bonds or other evidences of indebtedness, not in default as to principal or interest, which are valid and legally authorized obligations issued, assumed or guaranteed by the United States or Canada or by any state, territory, possession or province thereof, or by any county, city, town, village, municipality or other political subdivision or public instrumentality of one (1) or more of the governmental units specified, if, by statutory or other legal requirements applicable thereto, the obligations are payable as to both principal and interest from:

(A) Taxes levied or required to be levied upon all taxable property or all taxable income within the jurisdiction of the governmental unit; or

(B) Adequate special revenues pledged or otherwise appropriated or by law required to be provided for that payment, but not including any obligation payable solely out of special assessments on properties benefited by local improvements unless adequate security is evidenced by the ratio of assessment to the value of the property or the obligation is additionally secured by an adequate guaranty fund required by law.

(ii) The obligations and stock if stated, issued, assumed or guaranteed by the following agencies of the United States government, or in which that government is a participant, whether or not it guarantees the obligations:

(A) Commodity credit corporation;

(B) Federal intermediate credit banks;

(C) Federal land banks;

(D) Banks for cooperatives;

(E) Federal home loan banks, and stock thereof;

(F) Federal national mortgage association and stock thereof when acquired in connection with sale of mortgage loans to the association;

(G) International bank for reconstruction and development;

(H) Inter-American development bank;

(J) Any other similar agency of, or participated in by, the United States government and of similar financial quality.

(iii) Obligations other than those eligible for investment under W.S. 26-7-107(a)(xii) if they are issued, assumed or guaranteed by any solvent institution created or existing under the laws of the United States or Canada or of any state, district, territory or province thereof, and are qualified under any of the following:

(A) Obligations which are secured by adequate collateral security and bear fixed interest if during each of any three (3), including the last two (2), of the five (5) fiscal years immediately preceding the date of the insurer's acquisition, the net earnings of the issuing, assuming or guaranteeing institution available for its fixed charges, as defined in W.S. 26-7-102, have been not less than one and one-fourth (1 1/4) times the total of its fixed charges for that year. In determining the adequacy of collateral security not more than one-third (1/3) of the total value of the required collateral shall consist of stock other than stock meeting the requirements of W.S. 26-7-107(a)(iv);

(B) Fixed interest-bearing obligations, other than those described in subparagraph (a)(iii)(A) of this section, if the net earnings of the issuing, assuming or guaranteeing institution available for its fixed charges for a period of five (5) fiscal years immediately preceding the date of the insurer's acquisition have averaged per year not less than one and one-half (1 1/2) times its average annual fixed

charges applicable to that period and if during the last year of that period the net earnings have been not less than one and one-half (1 1/2) times its fixed charges for that year;

(C) Adjustment, income or other contingent interest obligations if the net earnings of the issuing, assuming or guaranteeing institution available for its fixed charges for a period of five (5) fiscal years immediately preceding the date of the insurer's acquisition have averaged per year not less than one and one-half (1 1/2) times the sum of its average annual fixed charges and its average annual maximum contingent interest applicable to that period and if during each of the last two (2) years of that period the net earnings have been not less than one and one-half (1 1/2) times the sum of its fixed charges and maximum contingent interest for each year.

(iv) Preferred or guaranteed stocks or shares of any solvent institution existing under the laws of the United States or of Canada, or of any state or province thereof, if all of the prior obligations and prior preferred stocks, if any, of the institution at the date of the insurer's acquisition of the investment are eligible as investments under this chapter and if the net earnings of the institution available for its fixed charges during each of the last two (2) years have been, and during each of the last five (5) years have averaged, not less than one and one-half (1 1/2) times the sum of its average annual fixed charges, if any, its average annual maximum contingent interest, if any, and its average annual preferred dividend requirements. For the purposes of this paragraph the computation shall refer to the fiscal years immediately preceding the date of the insurer's acquisition of the investment, and the term "preferred dividend requirement" means cumulative or noncumulative dividends, whether paid or not;

(v) Nonassessable common stocks, other than insurance stocks, of any solvent corporation organized and existing under the laws of the United States or Canada, or of any state or province thereof, if the corporation has had net earnings available for dividends on its stock in each of the five (5) fiscal years immediately preceding the insurer's investment therein. If the issuing corporation has not been in legal existence for the whole of the five (5) fiscal years but was formed as a consolidation or merger of two (2) or more businesses of which at least one (1) was in operation on a date five (5) years prior to the investment, the test of eligibility of its common stock under this paragraph shall be based upon

consolidated pro forma statements of the predecessor or constituent institutions;

(vi) Stocks of other solvent insurers formed under the laws of this or another state, which stocks meet the applicable requirements of W.S. 26-7-107(a)(iv) and 26-7-107(a)(v). With the commissioner's advance written consent an insurer may acquire and hold the controlling interest in the outstanding voting stock of another stock insurer formed under the laws of this or another state, which stocks are limited as to amount as provided in W.S. 26-7-107(a)(vii). The commissioner shall not give his consent to any such acquisition if he finds it is not in the best interests of the insurers involved or of their policyholders or stockholders, or that the acquisition would materially tend to result in any monopoly in the insurance business;

(vii) Stock of a subsidiary insurance corporation it forms. All of the insurer's investments under this paragraph, together with its investments in insurance stocks under W.S. 26-7-107(a)(vi), shall not at any time exceed the amount of the investing insurer's surplus, if a life insurer, or its surplus to policyholders if other than a life insurer;

(viii) A bank's common trust fund as defined in section 584 of the United States Internal Revenue Code of 1954;

(ix) The securities of any open-end management type investment company or investment trust registered with the federal securities and exchange commission under the Investment Company Act of 1940 as from time to time amended, if the investment company or trust has assets of not less than twenty-five million dollars ($25,000,000.00) on the date of the insurer's investment;

(x) Equipment trust obligations or certificates adequately secured and evidencing an interest in transportation equipment, wholly or in part within the United States of America, which obligations or certificates carry the right to receive determined portions of rental, purchase or other fixed obligatory payments to be made for the use or purchase of the transportation equipment;

(xi) Share accounts, savings accounts of savings and loan associations or building and loan associations or in the savings accounts of banks;

(xii) First liens upon improved real property located in this or any other state or in Canada, subject to the following conditions:

(A) For liens on single family residence property the amount loaned shall not exceed seventy-five percent (75%) of the fair value of the property, and the loan shall be amortized within not more than thirty (30) years by payment of installments thereon at regular intervals not less frequent than every three (3) months;

(B) For liens on other improved real property the amount loaned shall not exceed sixty-six and two-thirds percent (66 2/3%) of the fair value of the property;

(C) No loan shall be made or acquired by the insurer unless the fair value of the property has been determined, for the purposes of the loan, by a qualified independent appraiser;

(D) In applying the limitations provided in subparagraphs (A) and (B) of this paragraph, the amount in which the loan is guaranteed by the administrator of veteran's affairs or insured by the federal housing administration or other United States or Canadian government agency may be excluded from the amount of the loan;

(E) Insurance not less comprehensive than fire and extended coverage shall be carried on the improvements on the property in an amount not less than the insurable value of the improvements, or the amount of the loan, whichever is less, and the policy evidencing the insurance endorsed to show the interest of the mortgagee. "Improved real property" means all farm lands used for tillage, crop, other than timber, or pasture, and all real property on which permanent improvements, installations or structures suitable for residence or construction of residences, or for commercial or industrial use, are situated;

(F) Subparagraphs (A), (B) and (C) of this paragraph do not apply to purchase money mortgages taken by the insurer upon sale of property theretofore owned by it and covering the real property. No such mortgage shall be for an amount exceeding the original unpaid balance of the purchase price.

(xiii) Real property as follows:

(A) The land and the buildings thereon occupied by it as its principal office and any other real property necessary in the transaction of its business, provided the amount so invested and apportioned as to space actually so occupied shall not aggregate more than fifteen percent (15%) of the insurer's assets;

(B) Acquired in satisfaction of loans, mortgages, liens, judgments, decrees or debts previously owing to the insurer in the course of its business;

(C) Acquired in part payment of the consideration of the sale of other real property it owns, if the transaction effects a net reduction in the insurer's investments in real property;

(D) Acquired by gift or devise or through merger, consolidation or bulk reinsurance of another insurer under this code;

(E) The seller's interest in real property subject to an agreement of purchase or sale, but the sum invested in the seller's interest shall not exceed two-thirds (2/3) of the fair value of the property;

(F) Improved real property, or any interest therein acquired or held by purchase, lease or otherwise, other than real property to be used primarily for agricultural, ranch, mining, development of oil or mineral resources, recreational, amusement, hotel, motel or club purposes, acquired as an investment for the production of income or acquired to be improved or developed for such investment purposes pursuant to an existing program therefor. The insurer may hold, improve, develop, maintain, manage, lease, sell and convey real property it acquires under this provision. An insurer shall not have at any time invested in real property under this subparagraph an amount exceeding fifteen percent (15%) of its assets. An investment in any single parcel of real estate acquired under this subparagraph after March 1, 1975, shall not exceed four percent (4%) of the company's assets;

(G) Additional real property and equipment incident to real property, if necessary or convenient for the purpose of enhancing the sale or other value of real property previously acquired or held under subparagraphs (B), (C), (D) or (F) of this paragraph. The real property and equipment shall be

included, together with the real property for the enhancement of which it was acquired, for the purpose of applicable investment limits, and is subject to disposal at the same time and under the same conditions applying to the enhanced real property under W.S. 26-7-112;

(H) All real property owned by the insurer under this section, except as to seller's interest specified in subparagraph (E) of this paragraph, shall not at any time exceed thirty percent (30%) of the insurer's assets.

(xiv) Common stock, preferred stock, debt obligations, and other securities of one (1) or more subsidiary business corporations formed under the laws of this state and necessary and incidental to the insurer's insurance business or to the administration of any of its investments. The amount of the investment is governed by W.S. 26-44-102(b);

(xv) Nonassessable common stocks, other than insurance stocks, of any solvent corporation organized and existing under the laws of any foreign jurisdiction, any such investment to be subject to the limitations of W.S. 26-7-106;

(xvi) Digital assets, as defined by W.S. 34-29-101(a)(i) and excluding digital consumer assets as defined by W.S. 34-29-101(a)(ii), that otherwise comply with all applicable requirements of this chapter for the applicable asset class or for the most analogous asset class;

(xvii) Obligations issued by any solvent corporation in a foreign jurisdiction, other than an insurance company, that are traded in the United States on United States exchanges and denominated in United States dollars and subject to United States securities laws. The obligations must be high grade investments and are subject to the five percent (5%) limitation in W.S. 26-7-106(a)(i);

(xviii) Interests in a partnership or limited liability company, if the insurer has one hundred million dollars ($100,000,000.00) or more in surplus and a total adjusted capital that is at least five (5) times its authorized control level risk-based capital. An insurer's investment in any one partnership or limited liability company shall not exceed five percent (5%) of the insurer's admitted assets. The aggregate of all investments in partnerships and limited liability companies shall not exceed ten percent (10%) of the insurer's admitted assets;

(xix) Securities issued by an exchange-traded fund as defined in 17 C.F.R. 270.6c-11(a) as from time to time amended provided the following conditions are met:

(A) The exchange-traded fund is registered under the Investment Company Act of 1940 as from time to time amended;

(B) Shares of the exchange-traded fund are registered under the Securities Act of 1933 as from time to time amended;

(C) The exchange-traded fund is solvent and reported at least one hundred million dollars ($100,000,000.00) of net assets in the fund's most recent annual report or more recent audited financial statement; and

(D) Shares of the exchange-traded fund are listed and traded on a national securities exchange.

(b) At any one (1) time, the aggregate amount of foreign investments shall not exceed twenty percent (20%) of the insurer's admitted assets.

26-7-108. Policy loans.

A life insurer may lend to its policyholder upon pledge of the policy as collateral security any sum not exceeding the cash surrender value of the policy, or may lend against pledge or assignment of any of its supplementary contracts or other contracts or obligations if the loan is adequately secured by the pledge or assignment. Loans so made are eligible investments of the insurer.

26-7-109. Collateral loans.

An insurer may lend and thereby invest its funds upon the pledge of securities eligible for investment under this chapter. As of the date made, no such loan shall exceed in amount ninety percent (90%) of the market value of the collateral pledged. The amount loaned shall be included pro rata in determining the maximum percentage of funds permitted under this chapter to be invested in the categories of securities so pledged.

26-7-110. Miscellaneous loans and investments.

(a) An insurer may make loans or investments not otherwise expressly permitted under this chapter, in aggregate amounts not over five percent (5%) of the insurer's admitted assets and not over one percent (1%) of those assets as to any one loan or investment, if the loan or investment fulfills the requirements of W.S. 26-7-103 and otherwise qualifies as a sound investment. An insurer with one hundred million dollars ($100,000,000.00) or more in surplus and a total adjusted capital that is at least five (5) times its authorized control level risk-based capital may make loans or investments not otherwise expressly permitted under this chapter, in aggregate amounts not over ten percent (10%) of the insurer's admitted assets and not over two percent (2%) of those assets as to any one (1) loan or investment, if the loan or investment fulfills the requirements of W.S. 26-7-103 and otherwise qualifies as a sound investment. For all insurers, no such loan or investment shall be represented by:

(i) Any item excluded under W.S. 26-6-102 or any loan or investment otherwise expressly prohibited;

(ii) Agents' balances or amounts advanced to or owing by agents, except as to policy loans, mortgage loans and collateral loans otherwise authorized under this chapter;

(iii) Any category of loans or investments expressly eligible under any other provisions of this chapter;

(iv) Any asset theretofore acquired or held by the insurer under any other category of loans or investments eligible under this chapter.

(b) An insurer may make loans to industrial development corporations under the laws of this state in an amount not exceeding the limits set forth in W.S. 17-11-106(b)(iii).

(c) The insurer shall keep a separate record of all loans and investments made under this section.

26-7-111. Security interest in chattels.

(a) In connection with a mortgage loan on the security of real property designed and used primarily for residential purposes only, which mortgage loan was acquired pursuant to W.S. 26-7-107(a)(xii), an insurer may lend or invest an amount, not exceeding twenty percent (20%) of the amount loaned on or invested in the real property mortgage, on the security of chattels, to be amortized by regular payments within a term of

not more than five (5) years, and representing a first and prior lien, except for taxes not then delinquent, on personal property constituting durable equipment and owned by the mortgagor and kept and used in the mortgaged premises.

(b) For the purposes of this section, "durable equipment" includes only mechanical refrigerators, air conditioning equipment, mechanical laundering machines, heating and cooking stoves and ranges, and in the case of apartment houses, motels and hotels, room furniture and furnishings also.

(c) Prior to the acquisition of a chattel mortgage under this section, items of property to be included therein shall be separately appraised by a qualified appraiser and the fair market value thereof determined. No chattel loan shall exceed in amount the same ratio of loan to the value of the property as is applicable to the companion loan on the real property.

(d) This section does not prohibit an insurer from taking liens on personal property as additional security for any investment otherwise eligible under this chapter.

26-7-112. Security interest in chattels; time limit for disposal.

(a) Except as stated in subsection (b) of this section, the insurer shall dispose of real property acquired under W.S. 26-7-107(a)(xiii)(A) within five (5) years after it ceases to be necessary to the insurer in the transaction of its business and real property acquired under W.S. 26-7-107(a)(xiii)(B), (C) and (D) within five (5) years after the date of acquisition.

(b) Upon satisfactory proof that the insurer's interests will suffer materially by the forced sale of real property, the commissioner, by order, may grant a reasonable extension of the period within which the insurer shall dispose of any particular parcel of real property, unless the insurer elects to hold the real property as an investment for income purposes under W.S. 26-7-107(a)(xiii)(F), in which case thereafter the real property is deemed to have been acquired at a cost equal to its book value at the time of the election and to be held under and subject to that subparagraph.

26-7-113. Disposal of ineligible investments; time limit for disposal.

Any personal property or securities lawfully acquired by an insurer which it could not otherwise have invested in or loaned its funds upon at the time of the acquisition, shall be disposed of within three (3) years from date of acquisition unless within that period the security becomes an eligible investment, except that any security or personal property acquired under any agreement of bulk reinsurance, merger or consolidation may be retained for a longer period if so provided in the plan for reinsurance, merger or consolidation as the commissioner approves under chapter 24 of this code. Upon the insurer's application and proof that forced sale of any such property or security would materially injure its interests, the commissioner may extend the disposal period for an additional reasonable time.

26-7-114. Disposal of ineligible investments; failure to dispose; disposal of ineligible investments unlawfully acquired.

(a) Any real property, personal property or securities lawfully acquired and held by an insurer after expiration of the period for disposal thereof or any extension of that period as provided in W.S. 26-7-107(a)(vi) or 26-7-107(a)(vii), shall not be allowed as an insurer's asset.

(b) An insurer shall immediately dispose of any ineligible investment unlawfully acquired. The commissioner shall suspend or revoke the insurer's certificate of authority if the insurer fails to dispose of the investment within any reasonable time the commissioner, by order, specifies.

26-7-115. Prohibited investments; securities underwriting prohibited.

(a) In addition to investments excluded pursuant to other provisions of this code, an insurer shall not invest in or lend its funds upon the security of:

(i) Issued shares of its own capital stock, except for the purpose of mutualization under W.S. 26-24-143;

(ii) Securities issued by any corporation or enterprise the controlling interest of which is or after the insurer's acquisition will be held by the insurer or any combination of the insurer and the insurer's directors, officers, parent corporation, subsidiaries or controlling stockholders and the spouses and children of any of them. Investments in controlled insurance corporations or subsidiaries

under W.S. 26-7-107(a)(vi), (vii) or (xiv) are not subject to this provision;

(iii) Any note or other evidence of indebtedness of any director, officer, employee or controlling stockholder of the insurer or of the spouse or child of any of them, except as to policy loans authorized under W.S. 26-7-108.

(b) No insurer shall underwrite or participate in the underwriting of an offering of securities or property by any other person.

26-7-116. Investments of foreign insurers.

The investment portfolio of a foreign or alien insurer shall be as permitted by the laws of its domicile if of a quality substantially equal to that required under this chapter for similar funds of like domestic insurers. In determining the relative quality and value of the investment portfolio of a foreign or alien insurer, the commissioner, for purposes of comparison, may apply the provisions of this code regulating investments of domestic insurers and valuation of those insurers. If the commissioner determines that the investment portfolio of a foreign or alien insurer is not of a quality substantially equal to that required under this chapter for similar funds of like domestic insurers, he may refuse to continue or may suspend or revoke an insurer's certificate of authority in accordance with W.S. 26-3-115.

CHAPTER 8 - ADMINISTRATION OF ASSETS AND DEPOSITS

ARTICLE 1 - ADMINISTRATION OF DEPOSITS

26-8-101. Authorized deposits of insurers.

(a) The following deposits of insurers when made through the commissioner shall be accepted and held, subject to this chapter:

(i) Deposits required under this code for authority to transact insurance in this state;

(ii) Deposits of domestic insurers if made pursuant to the laws of other states, provinces and countries as a requirement for authority to transact insurance therein;

(iii) Deposits in any additional amounts permitted under W.S. 26-8-109(b).

26-8-102. Purposes for holding deposits.

(a) Deposits shall be held for purposes as follows:

(i) Deposits made in this state under W.S. 26-3-111 shall be held in trust for the purposes stated in that section;

(ii) A deposit made in this state by a domestic insurer transacting insurance in another state, province or country, as required by the laws thereof, shall be held in trust for the protection of all the insurer's policyholders or all its policyholders and creditors or for any other purpose specified by those laws;

(iii) A deposit required under W.S. 26-3-130 shall be held for purposes specified by the commissioner's order pursuant to which the deposit is to be made.

26-8-103. Securities eligible for deposit.

(a) Any deposits required under W.S. 26-3-111 for authority to transact insurance in this state shall consist of any combination of certificates of deposit issued by solvent banks, public obligations as described in W.S. 26-7-107(a)(i) or corporate obligations described in W.S. 26-7-107(a)(iii).

(b) Any other deposits of a domestic insurer held in this state pursuant to the laws of another state, province or country shall be comprised of assets described in subsection (a) of this section and of any additional securities required or permitted by those laws, except common stocks, mortgages of any kind and real property.

(c) Deposits of foreign insurers made in this state under W.S. 26-3-130 shall consist of assets the commissioner requires pursuant to that law.

26-8-104. Depository.

(a) Deposits made in this state under this code shall be made through and with the commissioner's approval in safe deposit with an established safe deposit institution, bank or trust company located in this state and selected by the insurer.

(b) If the deposit is kept in safe deposit, the box or compartment in which are kept the assets and securities comprising the deposit shall be placed in a fireproof safe deposit vault and shall require two (2) distinctly differing keys to open it. One (1) of the keys shall at all times be kept by the commissioner and the other key shall at all times be kept by the insurer. The box or compartment shall not at any time be opened or remain open except through the joint action and in the presence of both the commissioner and the insurer's authorized representative.

(c) The insurer shall pay the customary fees for the safekeeping of its deposit.

26-8-105. Custodial arrangements.

(a) Instead of deposit into safe deposit as provided in W.S. 26-8-104, upon the insurer's written request the commissioner may permit the insurer to make and maintain the deposit under custodial arrangements with the trust department of an established bank located in Wyoming.

(b) With the commissioner's written advance approval, the insurer may deposit certain of its securities under custodial arrangements with an established bank or trust company located outside this state, if the custodial bank or trust company issues original receipts for those securities and they are held in safe deposit or custody subject to the requirements of W.S. 26-8-104(b) or subsection (a) of this section.

(c) The form and terms of all such custodial arrangements shall be as the commissioner prescribes or approves consistent with the applicable provisions of this code [title 26].

(d) The insurer shall bear the costs of custodial arrangements.

26-8-106. Commissioner's record of deposits; vouchers as to assets deposited.

(a) The commissioner shall:

(i) Give the depositing insurer vouchers as to assets deposited with him;

(ii) Keep a record of the assets comprising each insurer's deposit, showing as far as practical the amount and

market value of each item and each of his transactions relative thereto.

26-8-107. Assignment or transfer of securities deposited to commissioner.

Any assets deposited by an insurer and not negotiable by delivery shall be assigned or transferred to the commissioner and his successors in office. Upon release of any such security or asset to the insurer, the commissioner shall reassign or transfer the security or asset to the insurer.

26-8-108. Appraisal of securities deposited.

Prior to acceptance for deposit of any asset, or at any time thereafter while so deposited, the commissioner may have the asset appraised or valued by competent appraisers. The insurer shall bear the reasonable costs of the appraisal or valuation.

26-8-109. When excess deposits may be required.

(a) If assets deposited by an insurer under this chapter are subject to material fluctuations in market value, the commissioner may require the insurer to deposit and maintain on deposit additional assets in an amount reasonably necessary to assure that the deposit at all times has a market value of not less than the amount specified under the law by which the deposit is required.

(b) An insurer not required to make additional deposits may deposit assets in an amount exceeding its deposit required or otherwise permitted under this code by not more than twenty percent (20%) of the required or permitted deposit, or twenty thousand dollars ($20,000.00), whichever is larger, for the purpose of absorbing fluctuations in the value of assets deposited and to facilitate exchange and substitution of those assets. During the insurer's solvency any excess deposit shall be released to the insurer upon its request. During the insurer's insolvency, an excess deposit shall be released only as provided in W.S. 26-8-113(d).

26-8-110. Rights of solvent insurer.

(a) If the insurer is solvent and in compliance with this code it may:

(i) Demand, receive, sue for and recover the income from the assets deposited;

(ii) Exchange and substitute for the deposited assets, or any part thereof, other eligible securities and assets of equivalent or greater market value; and

(iii) At any reasonable time inspect its deposit.

26-8-111. Levy upon deposit.

No judgment creditor or other claimant of an insurer has the right to levy upon any of the assets held in this state as a deposit for the protection of the insurer's policyholders or creditors or both. As to a deposit made pursuant to W.S. 26-3-111, levy on that deposit is permitted if provided in the commissioner's order under which the deposit is required.

26-8-112. Deficiency of deposit; failure to cure.

If for any reason the market value of an insurer's assets held on deposit in this state as required under this code falls below the required amount, the insurer shall promptly deposit other or additional assets eligible for deposit sufficient to cure the deficiency. If the insurer fails to cure the deficiency within twenty (20) days after receipt of notice thereof by registered or certified mail from the commissioner, the commissioner shall revoke the insurer's certificate of authority.

26-8-113. Duration and release of deposit.

(a) Any deposit an insurer makes in this state pursuant to this code, including assets held in another state under custodial arrangements permitted by W.S. 26-8-105(b), shall be held as long as:

(i) There is outstanding any liability of the insurer as to which the deposit was so required; or

(ii) The basis of retaliation exists if the deposit was required under W.S. 26-3-130.

(b) Upon a domestic insurer's request, the commissioner shall return to the insurer the whole or any portion of its assets held on deposit if the commissioner is satisfied that the assets to be returned are not subject to liability and are not required to be longer held by any provision of law or purposes

of the original deposit. If the insurer has reinsured all its outstanding risks in another insurer authorized to transact insurance in this state, the commissioner shall deliver the assets and securities to the insurer assuming the risks, upon the domestic insurer's written notice that the assets have been assigned and transferred to the reinsuring insurer. The notice shall be accompanied by a verified copy of the assignment or transfer.

(c) The commissioner shall return any deposit made in this state by a foreign insurer, if that insurer ceases transacting insurance in this state and is not subject to any liability in this state for which the deposit was held.

(d) If the insurer is subject to delinquency proceedings as defined in W.S. 26-28-101, upon the order of a court of competent jurisdiction the commissioner shall yield the insurer's assets held on deposit to the insurer's receiver, conservator, rehabilitator or liquidator, or to any other properly designated official who succeeds to the management and control of the insurer's assets.

(e) No release of deposited assets shall be made except upon application to and the written order of the commissioner. The commissioner has no personal liability for any release of any deposit or part thereof he makes in good faith.

26-8-114. Commissioner's liability.

If the commissioner willfully fails to require, deposit, keep, account and receipt for, or surrender in the manner by law authorized or required any assets as provided in this code, he is responsible upon his official bond therefor and suit may be brought upon his bond by any person injured by the failure.

ARTICLE 2 - HOLDING OF SECURITIES

26-8-201. Definitions.

(a) As used in this article:

(i) "Clearing corporation" means a corporation as defined in W.S. 34.1-8-102(a)(v), except that with respect to securities issued by institutions organized or existing under the laws of any foreign country or securities used to meet the deposit requirements pursuant to the laws of a foreign country as a condition of doing business therein, clearing corporation

may include a corporation which is organized or existing under the laws of any foreign country and is legally qualified under those laws to effect transactions in securities by computerized book-entry. Clearing corporation also includes the "treasury/reserve automated debt entry securities system" and the "treasury direct" book-entry securities systems established pursuant to 31 U.S.C. § 3100, et seq., 12 U.S.C. part 391 and 5 U.S.C. part 301;

(ii) Repealed By Laws 2007, Ch. 44, § 3.

(iii) Repealed By Laws 2007, Ch. 44, § 3.

(iv) Repealed By Laws 2007, Ch. 44, § 3.

(v) "Security" means as defined in W.S. 34.1-8-102(a)(xv);

(vi) "Custodian" means a national bank, state bank or a trust company which participates in a clearing corporation.

26-8-202. Use of book-entry systems.

(a) Notwithstanding any other provision of law, but subject to W.S. 26-24-129, a domestic insurer may deposit or arrange for the deposit of securities held in or purchased for its general account and its separate accounts in a clearing corporation. When securities are deposited with a clearing corporation, certificates representing securities of the same class of the same issuer may be merged and held in bulk in the name of the nominee of the clearing corporation with any other securities deposited with the clearing corporation by any person, regardless of the ownership of the securities, and certificates representing securities of small denominations may be merged into one (1) or more certificates of larger denominations. The records of any custodian through which an insurer holds securities in a clearing corporation, shall at all times show that the securities are held for the insurer and the accounts in which they are held. Ownership of, and other interests in, the securities may be transferred by bookkeeping entry on the books of the clearing corporation without physical delivery of certificates representing the securities.

(b) The commissioner is authorized to promulgate rules and regulations governing the deposit by insurers of securities with clearing corporations, including establishing standards for

national banks, state banks and trust companies to qualify as custodians for insurance company securities.

26-8-203. Deposit of securities by insurers.

Notwithstanding any other provision of law, the securities qualified for deposit under this chapter may be deposited with a clearing corporation. Securities deposited with a clearing corporation and used to meet the deposit requirements set forth in chapter 3 of this code shall be under the control of the commissioner and shall not be withdrawn by the insurer without the approval of the commissioner. Any insurer holding securities in this manner shall provide to the commissioner evidence issued by its custodian through which the insurer has deposited the securities in a clearing corporation in order to establish that the securities are actually recorded in an account in the name of the custodian and that the records of the custodian reflect that the securities are held subject to the order of the commissioner.

26-8-204. Deposit of securities by foreign insurers.

Notwithstanding any other provision of law, securities eligible for deposit under the insurance laws of this state relating to deposit of securities by an insurer as a condition of commencing or continuing to do an insurance business in this state may be deposited with a clearing corporation. Securities deposited with a clearing corporation and used to meet the deposit requirements under the insurance laws of this state shall be under the control of the commissioner and shall not be withdrawn by the insurer without the approval of the commissioner. Any insurer holding securities in this manner shall provide to the commissioner evidence issued by its custodian in order to establish that the securities are actually recorded in an account in the name of the custodian and evidence that the records of the custodian reflect that the securities are held subject to the order of the commissioner.

CHAPTER 9 - AGENCIES AND ADJUSTERS

ARTICLE 1 - IN GENERAL

26-9-101. Repealed by Laws 2001, Ch. 201, § 5.

26-9-102. Repealed by Laws 2001, Ch. 201, § 5.

26-9-103. Repealed by Laws 2001, Ch. 201, § 5.

26-9-104. Amended and renumbered as W.S. 26-9-226 by Laws 2001, Ch. 201, § 3.

26-9-105. Repealed by Laws 2001, Ch. 201, § 5.

26-9-106. Repealed by Laws 2001, Ch. 201, § 5.

26-9-107. Repealed by Laws 2001, Ch. 201, § 5.

26-9-108. Repealed by Laws 2001, Ch. 201, § 5.

26-9-109. Repealed by Laws 2001, Ch. 201, § 5.

26-9-110. Repealed by Laws 2001, Ch. 201, § 5.

26-9-111. Repealed by Laws 2001, Ch. 201, § 5.

26-9-112. Repealed by Laws 2001, Ch. 201, § 5.

26-9-113. Repealed by Laws 2001, Ch. 201, § 5.

26-9-114. Repealed by Laws 2001, Ch. 201, § 5.

26-9-115. Repealed by Laws 2001, Ch. 201, § 5.

26-9-116. Amended and renumbered as W.S. 26-9-227 by Laws 2001, Ch. 201, § 3.

26-9-117. Repealed by Laws 2001, Ch. 201, § 5.

26-9-118. Repealed by Laws 2001, Ch. 201, § 5.

26-9-119. Repealed by Laws 2001, Ch. 201, § 5.

26-9-120. Repealed by Laws 2001, Ch. 201, § 5.

26-9-121. Repealed by Laws 2001, Ch. 201, § 5.

26-9-122. Repealed by Laws 2001, Ch. 201, § 5.

26-9-123. Repealed by Laws 2001, Ch. 201, § 5.

26-9-124. Amended and renumbered as W.S. 26-9-223 by Laws 2001, Ch. 201, § 3.

26-9-125. Amended and renumbered as W.S. 26-9-224 by Laws 2001, Ch. 201, § 3.

26-9-126. Amended and renumbered as W.S. 26-9-225 by Laws 2001, Ch. 201, § 3.

26-9-127. Repealed by Laws 2001, Ch. 201, § 5.

26-9-128. Repealed by Laws 2001, Ch. 201, § 5.

26-9-129. Amended and renumbered as W.S. 26-9-228 by Laws 2001, Ch. 201, § 3.

26-9-130. Amended and renumbered as W.S. 26-9-229 by Laws 2001, Ch. 201, § 3.

26-9-131. Repealed by Laws 2001, Ch. 201, § 5.

26-9-132. Repealed by Laws 2001, Ch. 201, § 5.

26-9-133. Repealed by Laws 2001, Ch. 201, § 5.

26-9-134. Amended and renumbered as W.S. 26-9-230 by Laws 2001, Ch. 201, § 3.

26-9-135. Amended and renumbered as W.S. 26-9-219 by Laws 2001, Ch. 201, § 3.

26-9-136. Repealed by Laws 2001, Ch. 201, § 5.

26-9-137. Repealed by Laws 2001, Ch. 201, § 5.

26-9-138. Renumbered as W.S. 26-9-232 by Laws 2001, Ch. 201, § 4.

26-9-139. Amended and renumbered as W.S. 26-9-220 by Laws 2001, Ch. 201, § 3.

26-9-140. Amended and renumbered as W.S. 26-9-221 by Laws 2001, Ch. 201, § 3.

26-9-141. Amended and renumbered as W.S. 26-9-231 by Laws 2001, Ch. 201, § 3.

26-9-142. Amended and renumbered as W.S. 26-9-222 by Laws 2001, Ch. 201, § 3.

ARTICLE 2 - INSURANCE PRODUCERS

26-9-201. Purpose and scope.

This chapter governs the qualifications and procedures for the licensing of insurance producers. This chapter does not apply to excess and surplus lines brokers licensed pursuant to W.S. 26-11-112 except as provided in W.S. 26-9-207(b) through (d), (f) and (g), 26-9-208, 26-9-216 and 26-9-230 or as expressly provided in chapter 11 of this code.

26-9-202. Definitions.

(a) As used in this chapter:

(i) "Business entity" means a corporation, association, partnership, limited liability company, limited liability partnership or other legal entity;

(ii) "Endorsee" means an employee or representative of a specialty limited lines producer;

(iii) "Home state" means the District of Columbia and any state or territory of the United States in which an insurance producer maintains his principal place of residence or principal place of business and is licensed to act as an insurance producer;

(iv) "License" means a document issued by the commissioner authorizing a person to act as an insurance producer for the lines of authority specified in the document. The license itself does not create any authority, actual, apparent or inherent, in the holder to represent or commit an insurer;

(v) "Limited line credit insurance" includes credit life, credit disability, credit property, credit unemployment, involuntary unemployment, mortgage life, mortgage guaranty, mortgage disability, guaranteed automobile protection insurance, and any other form of insurance offered in connection with an extension of credit that is limited to partially or wholly extinguishing that credit obligation that the commissioner determines should be designated a form of limited line credit insurance;

(vi) "Limited line credit insurance producer" means a person who sells, solicits or negotiates one (1) or more forms

of limited line credit insurance coverage to individuals through a master, corporate, group or individual policy;

(vii) "Limited lines insurance" means those lines of insurance referred to in paragraph (xxi) of this subsection and W.S. 26-9-234, 26-32-101, 26-37-102(a)(iv) or any other line of insurance the commissioner deems necessary to recognize for the purposes of complying with W.S. 26-9-208(e);

(viii) "Limited lines producer" means a person authorized by the commissioner to sell, solicit or negotiate limited lines insurance;

(ix) "Location" means any physical location in the state of Wyoming or any website, call center site or similar location directed to residents of the state of Wyoming;

(x) "Negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms or conditions of the contract, provided that the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers;

(xi) "Portable electronic device insurance" means insurance which may be offered on a month to month or other periodic basis as a group or master property and casualty insurance policy providing coverage for the repair or replacement of portable electronic devices which may provide coverage for portable electronic devices against any one (1) or more of the following causes of loss: loss, theft, inoperability due to mechanical failure, malfunction, damage or other similar causes of loss. For purposes of this title, with respect to portable electronic device insurance, property and casualty insurance shall be deemed to include inland marine insurance. Portable electronic device insurance does not include a service contract as defined in chapter 49 of this title;

(xii) "Rental car insurance" means insurance offered, sold or solicited in connection with and incidental to the rental of rental cars, whether at the rental office or by preselection of coverage in master, corporate, group or individual agreements that is nontransferable, applies only to the rental car that is the subject of the rental agreement and is limited to the following kinds of insurance and shall not

include the rental car company's agreement to waive its right of indemnity against a renter for damages to the rental vehicle:

(A) Personal accident insurance for renters and other rental car occupants, for accidental death or dismemberment and for medical expenses resulting from an accident that occurs with the rental car during the rental period;

(B) Liability insurance, which at the exclusive option of the rental car company, may include uninsured or underinsured motorist coverage, whether offered separately or in combination with other liability insurance, that provides protection to the renters and to other authorized drivers of a rental car for liability arising from the operation of the rental car during the rental period;

(C) Personal effects insurance that provides coverage to renters and other vehicle occupants for loss of or damage to, personal effects in the rental car during the rental period;

(D) Roadside assistance and emergency sickness protection insurance; or

(E) Any other insurance product sold incidental to the rental transaction.

(xiii) "Sell" means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurer;

(xiv) "Solicit" means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular insurer;

(xv) "Specialty limited lines insurance" means insurance offered or disseminated in connection with and ancillary to a specialty limited lines producer's core business. The term includes the following types of insurance: rental car insurance, portable electronic device insurance, travel insurance and any other line of insurance the commissioner deems necessary;

(xvi) "Specialty limited lines producer" means a person or business entity licensed as a limited lines producer

and qualified to offer, sell or solicit specialty limited lines insurance;

(xvii) "Terminate" means the cancellation of the relationship between an insurance producer and the insurer or the termination of a producer's authority to transact insurance;

(xviii) "Travel insurance" means insurance coverage for personal risks incident to planned travel, including but not limited to interruption or cancellation of trip or event, loss of baggage or personal effects, damages to accommodations or rental vehicles, and sickness, accident, disability or death occurring during travel, and does not include major medical plans, which provide comprehensive medical protection for travelers with trips lasting six (6) months or longer;

(xix) "Uniform application" means the current version of the National Association of Insurance Commissioners' uniform application for resident and nonresident producer licensing;

(xx) "Uniform business entity application" means the current version of the National Association of Insurance Commissioners' uniform business entity application for resident and nonresident business entities;

(xxi) "Crop insurance" means insurance providing protection against damage to crops from unfavorable weather conditions, fire, lightning, flood, hail, insect infestation, disease or other yield-reducing conditions or perils provided by the private insurance market or that is provided by the federal crop insurance corporation, including multi-peril crop and protection of revenue from adverse market fluctuation insurance.

(xxii) "Continuing education provider" means any person approved by the commissioner to offer continuing education courses to persons licensed in this state;

(xxiii) "Public adjuster" means any person who, for compensation or any other thing of value, acts on behalf of an insured by doing any of the following:

(A) Acting for or aiding an insured in negotiating for or in effecting the settlement of a first party claim for loss or damage to real or personal property of the insured;

(B) Advertising for employment as a public adjuster of first party claims or otherwise soliciting business or representing to the public that the person is a public adjuster of first party claims for loss or damage to real or personal property of an insured;

(C) Directly or indirectly soliciting the business of investigating or adjusting losses, or of advising an insured about first party claims for loss or damage to real or personal property of the insured.

(xxiv) "Licensee" means any person granted a license under this chapter;

(xxv) "Adjuster" means any individual who either investigates and negotiates settlements relative to insurance claims or applies the factual circumstances of an insurance claim to the insurance policy provisions, or both, arising under property and casualty insurance contracts. An attorney-at-law who is licensed to practice law in this state or a licensed agent or broker who adjusts or assists in adjustment of losses arising under policies issued through that broker or by the insurer represented by that agent, is not an adjuster for the purposes of this chapter. An appraiser or umpire is not an adjuster for the purposes of this chapter;

(xxvi) "Appraiser" means a person selected by the insurer or the insured to place a value on or estimate the amount of loss pursuant to an insurance claim. An appraiser does not negotiate settlements relative to insurance claims or apply the factual circumstances of an insurance claim to the insurance policy provisions;

(xxvii) "Umpire" means a person selected by the appraisers representing the insurer and the insured or, if the appraisers cannot agree, by the court or hearing officer charged with resolving issues that the appraisers are unable to agree upon during the appraisal.

26-9-203. License required.

A person shall not sell, solicit or negotiate insurance in this state for any class or classes of insurance unless the person is licensed for that line of authority in accordance with this chapter.

26-9-204. Exceptions to licensing.

(a) Nothing in this chapter shall be construed to require an insurer to obtain an insurance producer license. As used in this section, the term "insurer" does not include an insurer's officers, directors, employees, subsidiaries or affiliates.

(b) A license as an insurance producer shall not be required of the following:

(i) An officer, director or employee of an insurer or of an insurance producer, provided that the officer, director or employee does not receive any commission on policies written or sold to insure risks residing, located or to be performed in this state, and:

(A) The officer, director or employee's activities are executive, administrative, managerial, clerical or a combination of these, and are only indirectly related to the sale, solicitation or negotiation of insurance; or

(B) The officer, director or employee's function relates to underwriting, loss control, inspection or the processing, adjusting, investigating or settling of a claim on a contract of insurance; or

(C) The officer, director or employee is acting in the capacity of a special agent or agency supervisor assisting insurance producers where the person's activities are limited to providing technical advice and assistance to licensed insurance producers and do not include the sale, solicitation or negotiation of insurance.

(ii) A person who receives no commission and provides the following services:

(A) Secures and furnishes information for the purpose of group life insurance, group property and casualty insurance, group annuities, group or blanket accident and health or disability insurance; or

(B) Secures and furnishes information for the purpose of enrolling individuals under plans, issuing certificates under plans or otherwise assisting in administering plans; or

(C) Performs administrative services related to mass marketed property and casualty insurance.

(iii) An employer or association or its officers, directors, employees, or the trustees of an employee trust plan, to the extent that the employers, officers, employees, directors or trustees are engaged in the administration or operation of a program of employee benefits for the employer's or association's own employees or the employees of its subsidiaries or affiliates, which program involves the use of insurance issued by an insurer, as long as the employers, associations, officers, directors, employees or trustees are not in any manner compensated, directly or indirectly, by the company issuing the contracts;

(iv) Employees of insurers or organizations employed by insurers who are engaging in the inspection, rating or classification of risks, or in the supervision of the training of insurance producers and who are not individually engaged in the sale, solicitation or negotiation of insurance;

(v) A person whose activities in this state are limited to advertising without the intent to solicit insurance in this state through communications in printed publications or other forms of electronic mass media whose distribution is not limited to residents of the state, provided that the person does not sell, solicit or negotiate insurance that would insure risks residing, located or to be performed in this state;

(vi) A person who is not a resident of this state who sells, solicits or negotiates a contract of insurance for commercial property and casualty risks to an insured with risks located in more than one (1) state insured under that contract, provided that person is otherwise licensed as an insurance producer to sell, solicit or negotiate the insurance in the state where the insured maintains its principal place of business and the contract of insurance insures risks located in that state; or

(vii) A salaried full-time employee who counsels or advises his employer relative to the insurance interests of the employer or of the subsidiaries or business affiliates of the employer provided the employee does not sell or solicit insurance or receive a commission.

26-9-205. Application for examination.

(a) A resident individual applying for an insurance producer license shall pass a written examination unless exempt

pursuant to W.S. 26-9-209. The examination shall test the knowledge of the individual concerning the lines of authority for which application is made, the duties and responsibilities of an insurance producer and the insurance laws and regulations of this state. Examinations required by this section shall be developed and conducted by the commissioner who may promulgate appropriate rules and regulations on the administration of examinations.

(b) The commissioner may make arrangements, including contracting with an outside testing service, for administering examinations. If an outside testing service is employed, each individual applying for an examination shall remit the appropriate fee for the examination to the testing service.

26-9-206. Application for license.

(a) A person applying for a resident insurance producer license shall make application to the commissioner on the uniform application and declare under penalty of refusal, suspension or revocation of the license that the statements made in the application are true, correct and complete to the best of the individual's knowledge and belief. Before approving the application, the commissioner shall find that the individual:

(i) Is at least eighteen (18) years of age;

(ii) Has not committed any act that is a ground for denial, suspension or revocation set forth in W.S. 26-9-211;

(iii) Has paid the fees set forth in W.S. 26-4-101(a);

(iv) Has successfully passed the examinations for the lines of authority for which the person has applied; and

(v) Has provided the commissioner fingerprints and other information and permission necessary for a criminal history record background check as provided in W.S. 7-19-201(a). The cost of the criminal history record background check shall be paid by the applicant.

(b) A business entity acting as an insurance producer is required to obtain an insurance producer license. Application shall be made using the uniform business entity application. Before approving the application, the commissioner shall find that:

(i) The business entity has paid the fees set forth in W.S. 26-4-101(a); and

(ii) The business entity has designated a licensed producer responsible for the business entity's compliance with the insurance laws, rules and regulations of this state.

(c) The commissioner may require any documents reasonably necessary to verify the information contained in an application.

(d) Each insurer that sells, solicits or negotiates any form of limited line credit insurance shall provide to each individual whose duties will include selling, soliciting or negotiating limited line credit insurance a program of instruction.

26-9-207. License.

(a) Unless denied licensure pursuant to W.S. 26-9-211, persons who have met the requirements of W.S. 26-9-205 and 26-9-206 shall be issued an insurance producer license. An insurance producer may receive qualification for a license in one (1) or more of the following lines of authority:

(i) Life-insurance coverage on human lives including benefits of endowment and annuities, and may include benefits in the event of death or dismemberment by accident and benefits for disability income;

(ii) Accident and health or sickness or disability-insurance coverage for sickness, bodily injury or accidental death and may include benefits for disability income;

(iii) Property-insurance coverage for the direct or consequential loss or damage to property of every kind;

(iv) Casualty-insurance coverage against legal liability, including that for death, injury or disability or damage to real or personal property;

(v) Variable life and variable annuity products-insurance coverage provided under variable life insurance contracts and variable annuities;

(vi) Personal lines-property and casualty insurance coverage sold to individuals and families for primarily noncommercial purposes;

(vii) Credit-limited line credit insurance;

(viii) Any other line of insurance permitted under state laws or regulations.

(b) A licensee's license shall remain in effect unless revoked or suspended if on or before the last day of the month of the licensee's birthday in the second year following the issuance or renewal of the license the continuation fee set forth in W.S. 26-4-101(a) is paid, the continuing education requirements are met by the due date, a written request for continuation of the license is made to the commissioner on forms prescribed by the commissioner and the licensee remains in compliance with all other applicable provisions of this code. An insurance producer or surplus lines broker license issued to a business entity shall remain in effect unless revoked or suspended if on or before the last day of the month in which the license was effective in the second year following the issuance or renewal of the license the continuation fee set forth in W.S. 26-4-101(a) is paid, a written request for continuation of the license is made to the commissioner on forms prescribed by the commissioner and the licensee remains in compliance with all other applicable provisions of this code.

(c) A licensee who allows his license to lapse may, within twelve (12) months from the due date of the continuation fee, reinstate the same license without the necessity of passing a written examination. However, a penalty equal to the amount of the continuation fee shall be required in addition to the continuation fee for any continuation request received after the due date. A business entity insurance producer or surplus lines broker that allows its license to lapse may, within twelve (12) months from the due date of the continuation fee, reinstate the same license, however, a penalty equal to the amount of the continuation fee shall be required in addition to the continuation fee for any continuation request received after the due date.

(d) A licensee who is unable to comply with license renewal procedures due to military service or some other extenuating circumstance such as a long-term medical disability may request a waiver of those procedures. The producer may also request a waiver of any examination requirement or any other

fine or sanction imposed for failure to comply with renewal procedures.

(e) The license shall contain the licensee's name, address, personal identification number, date of issuance, the lines of authority, the expiration date and any other information the commissioner deems necessary.

(f) Licensees shall inform the commissioner by any means acceptable to the commissioner of a change of name, address, telephone number, email address or other contact information as defined by rule and regulation of the commissioner within thirty (30) days of the change.

(g) The commissioner may contract with nongovernmental entities, including the National Association of Insurance Commissioners or any affiliates or subsidiaries that association oversees, to perform any ministerial functions, including the collection of fees, related to licensing that the commissioner and the nongovernmental entity may deem appropriate.

(h) Repealed By Laws 2011, Ch. 60, § 3.

(j) Repealed By Laws 2011, Ch. 60, § 3.

26-9-208. Nonresident licensing.

(a) Unless denied licensure pursuant to W.S. 26-9-211, a nonresident person shall receive a nonresident producer license if:

(i) The person is currently licensed as a resident and is in good standing in his home state;

(ii) The person has submitted the proper request for licensure and has paid the fees required by W.S. 26-4-101(a);

(iii) The person has submitted or transmitted to the commissioner the application for licensure the person submitted to his home state, or in lieu of the same, a completed uniform application; and

(iv) The person's home state awards nonresident producer licenses to residents of this state on the same basis.

(b) The commissioner may verify the producer's licensing status through the producer database maintained by the National

Association of Insurance Commissioners, its affiliates or subsidiaries.

(c) A nonresident producer who moves from one (1) state to another or a resident producer who moves from this state to another state shall file a change of address and provide certification from the new resident state within thirty (30) days of the change of legal residence. No fee or license application is required.

(d) Notwithstanding any other provision of this chapter, a person licensed as a surplus lines producer in his home state shall receive a nonresident surplus lines producer license pursuant to subsection (a) of this section. Except as to subsection (a) of this section, nothing in this section otherwise amends or supercedes any provision of chapter 11 of this code.

(e) Notwithstanding any other provision of this chapter, a person licensed as a limited line credit insurance or other type of limited lines producer in his home state shall receive a nonresident limited lines producer license, pursuant to subsection (a) of this section, granting the same scope of authority as granted under the license issued by the producer's home state. For the purposes of this subsection, limited line insurance is any authority granted by the home state which restricts the authority of the license to less than the total authority prescribed in the associated major lines pursuant to W.S. 26-9-207(a)(i) through (vi).

26-9-209. Exemption from examination.

(a) An individual who applies for an insurance producer license in this state who was previously licensed for the same lines of authority in another state shall not be required to complete an examination. This exemption is only available if the person is currently licensed in that state or if the application is received within ninety (90) days of the cancellation of the applicant's previous license and if the prior state issues a certification that, at the time of cancellation, the applicant was in good standing in that state or the state's producer database records, maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries, indicate that the producer is or was licensed in good standing for the line of authority requested.

(b) A person licensed as an insurance producer in another state who moves to this state shall make application within ninety (90) days of establishing legal residence to become a resident licensee pursuant to W.S. 26-9-206. No examination shall be required of that person to obtain any line of authority previously held in the prior state except where the commissioner determines otherwise by regulation.

(c) Repealed By Laws 2013, Ch. 123, § 3.

26-9-210. Temporary licensing.

(a) The commissioner may issue a temporary insurance producer license for a period not to exceed one hundred eighty (180) days without requiring an examination if the commissioner deems that the temporary license is necessary for the servicing of an insurance business in the following cases:

(i) To the surviving spouse or court-appointed personal representative of a licensed insurance producer who dies or becomes mentally or physically disabled to allow adequate time for the sale of the insurance business owned by the producer or for the recovery or return of the producer to the business or to provide for the training and licensing of new personnel to operate the producer's business;

(ii) To a member or employee of a business entity licensed as an insurance producer, upon the death or disability of an individual designated in the business entity application or the license;

(iii) To the designee of a licensed insurance producer entering active service in the armed forces of the United States; or

(iv) In any other circumstance where the commissioner deems that the public interest will best be served by the issuance of this license.

(b) The commissioner may by order limit the authority of any temporary licensee in any way deemed necessary to protect insureds and the public. The commissioner may require the temporary licensee to have a suitable sponsor who is a licensed producer or insurer and who assumes responsibility for all acts of the temporary licensee and may impose other similar requirements designed to protect insureds and the public. The commissioner may by order revoke a temporary license if the

interest of insureds or the public are endangered. A temporary license may not continue after the owner or the personal representative disposes of the business.

26-9-211. License denial, nonrenewal or revocation.

(a) The commissioner may, after appropriate notice and opportunity for hearing pursuant to the Wyoming Administrative Procedure Act and in accordance with W.S. 26-2-125 through 26-2-129, place on probation, suspend, revoke or refuse to issue or renew an insurance producer's license or other license issued under this code, or may levy a civil penalty in accordance with W.S. 26-1-107 or any combination of actions, for any one (1) or more of the following causes:

(i) Providing incorrect, misleading, incomplete or materially untrue information in the license application;

(ii) Violating any insurance laws, or violating any regulation, subpoena or order of the commissioner or of another state's insurance commissioner;

(iii) Obtaining or attempting to obtain a license through misrepresentation or fraud;

(iv) Improperly withholding, misappropriating or converting any monies or properties received in the course of doing insurance business;

(v) Intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance;

(vi) Having been convicted of a felony that relates to the insurance profession or to the ability to practice as an insurance producer. For agents whose home state of licensure is not Wyoming, the commissioner may rely on licensure and disciplinary actions by the agent’s home state of licensure;

(vii) Having admitted or been found to have committed any insurance unfair trade practice or fraud;

(viii) Using fraudulent, coercive or dishonest practices, or demonstrating incompetence, untrustworthiness or financial irresponsibility in the conduct of business in this state or elsewhere;

(ix) Having an insurance producer license, or its equivalent, denied, suspended or revoked in any other state, province, district or territory;

(x) Forging another's name to an application for insurance or to any document related to an insurance transaction;

(xi) Improperly using notes or any other reference material to complete an examination for an insurance license;

(xii) Failing to comply with an administrative or court order imposing a child support obligation;

(xiii) Failing to maintain a valid home state license.

(b) The license of a business entity may be suspended, revoked or refused if the commissioner finds, after notice and opportunity for hearing, that an individual licensee's violation was known by one (1) or more of the partners, officers or managers acting on behalf of the business entity and the violation was neither reported to the commissioner nor corrective action taken.

(c) The commissioner shall retain the authority to enforce the provisions of and impose any penalty or remedy authorized by this chapter and this code against any person who is under investigation for or charged with a violation of this chapter or this code even if the person's license or registration has been surrendered or has lapsed by operation of law.

(d) The commissioner may, after providing appropriate notice and opportunity for hearing as required in subsection (a) of this section, levy against any person against whom action has been taken by the commissioner the reasonable costs of investigation and administrative proceedings, not to exceed five hundred dollars ($500.00).

(e) For persons for whom Wyoming is the home state of licensure, if the commissioner is aware at the time the commissioner takes an action under subsection (a) of this section that a person will require the written consent of an insurance regulatory official to engage in the business of insurance pursuant to 18 U.S.C. § 1033 and the result of the action under subsection (a) of this section is that the person

will receive or retain a license under this code, the commissioner shall, upon request, issue the written consent.

(f) If an employer becomes aware that an employee who is engaged in the business of insurance needs the commissioner's consent to continue to engage in the business of insurance, the employer may direct the employee to obtain the necessary consent and, if the consent is denied, shall take action so that the employee is not engaged in the business of insurance. In cases arising under this subsection the commissioner shall give special weight to evidence, including statements from the employer, as to whether the employee has or has not engaged in any activity that relates to the offense requiring the written consent and that relates adversely to the insurance profession.

26-9-212. Commissions.

(a) An insurer or insurance producer shall not pay a commission, service fee, brokerage or other valuable consideration to a person for selling, soliciting or negotiating insurance in this state if that person is required to be licensed under this chapter and is not so licensed.

(b) A person shall not accept a commission, service fee, brokerage or other valuable consideration for selling, soliciting or negotiating insurance in this state if that person is required to be licensed under this chapter and is not so licensed.

(c) Renewal or other deferred commissions may be paid to a person for selling, soliciting or negotiating insurance in this state if the person was required to be licensed under this chapter at the time of the sale, solicitation or negotiation and was so licensed at that time.

(d) An insurer or insurance producer may pay or assign commissions, brokerages or other valuable consideration to an insurance agency or to persons who do not sell, solicit or negotiate insurance in this state, unless the payment would violate W.S. 26-13-109 or 26-13-110.

26-9-213. Appointments.

(a) An insurance producer shall not act as an agent of an insurer unless the insurance producer becomes an appointed agent of that insurer. An insurance producer who is not acting as an agent of an insurer is not required to become appointed.

(b) To appoint a producer as its agent, the appointing insurer shall file, in a format approved by the commissioner, a notice of appointment within fifteen (15) days from the date the agency contract is executed or the first insurance application is submitted. An insurer may also elect to appoint a producer to all or some insurers within the insurer's holding company system or group by the filing of a single appointment request.

(c) Upon receipt of the notice of appointment, the commissioner shall verify within a reasonable time that the insurance producer is eligible for appointment. If the insurance producer is determined to be ineligible for appointment, the commissioner shall notify the insurer.

(d) An insurer shall pay an appointment fee, in the amount set forth in W.S. 26-4-101(a), for each insurance producer appointed by the insurer.

(e) An insurer shall remit, on or before March 31 and in a manner prescribed by the commissioner, an annual continuation appointment fee in the amount set forth in W.S. 26-4-101(a).

26-9-214. Notification to commissioner of termination.

(a) An insurer or authorized representative of the insurer that terminates the appointment, employment, contract or other insurance business relationship with a producer for any reason shall notify the commissioner within thirty (30) days following the effective date of the termination, using a format prescribed by the commissioner. Upon written request of the commissioner, the insurer shall provide additional information, documents, records or other data pertaining to the termination or activity of the producer.

(b) The insurer or the authorized representative of the insurer shall promptly notify the commissioner in a format acceptable to the commissioner if, upon further review or investigation, the insurer discovers additional information that would have been reportable to the commissioner under subsection (a) of this section had the insurer known of its existence.

(c) Within fifteen (15) days after making the notification required by subsections (a) and (b) of this section, the insurer shall mail a copy of the notification to the producer at his last known address.

(d) Within thirty (30) days after the producer has received the original or additional notification, the producer may file written comments concerning the substance of the notification with the commissioner. The producer shall, by the same means, simultaneously send a copy of the comments to the reporting insurer, and the comments shall be part of the commissioner's file and accompany every copy of a report distributed or disclosed for any reason about the producer as permitted under subsection (e) or (f) of this section.

(e) Any documents, materials or other information in the control or possession of the department that is furnished by an insurer, producer or an employee or agent thereof acting on behalf of the insurer or producer, or obtained by the commissioner in an investigation pursuant to this section shall be confidential by law and privileged, shall not be subject to W.S. 16-4-201 through 16-4-205, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. The commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's duties. Neither the commissioner nor any person who received documents, materials or other information while acting under the authority of the commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials or information subject to this subsection or subsection (f) of this section. In order to assist in the performance of the commissioner's duties under this code, the commissioner:

(i) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to this subsection, with other state, federal and international regulatory agencies, with the National Association of Insurance Commissioners, its affiliates or subsidiaries, and with state, federal and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material or other information;

(ii) May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the National Association of Insurance Commissioners, its affiliates or subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with

notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(iii) May enter into agreements governing sharing and use of information consistent with this subsection.

(f) No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in subsection (e) of this section. Nothing in this chapter shall prohibit the commissioner from releasing final, adjudicated actions including termination causes to a database or other clearinghouse service maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries.

(g) An insurer, the authorized representative of the insurer, or producer that fails to report as required under the provisions of this section or that is found to have reported with actual malice by a court of competent jurisdiction may, after notice and opportunity for hearing, have its license or certificate of authority suspended or revoked and may be fined in accordance with W.S. 26-1-107.

26-9-215. Reciprocity.

(a) The commissioner shall waive any requirements for a nonresident license applicant with a valid license from his home state, except the requirements imposed by W.S. 26-9-208, if the applicant's home state awards nonresident licenses to residents of this state on the same basis.

(b) In order to carry out the provisions of subsection (a) of this section, the commissioner may negotiate and enter into reciprocal arrangements with the insurance supervisory official of any other state or province.

26-9-216. Reporting of actions.

(a) A licensee shall report to the commissioner any administrative action taken against the licensee in another jurisdiction or by another governmental agency in this state within thirty (30) days of the final disposition of the matter. This report shall include a copy of the order, consent to order or other relevant legal documents.

(b) Within thirty (30) days of the initial pretrial hearing date, a licensee shall report to the commissioner any criminal prosecution of the licensee taken in any jurisdiction. The report shall include a copy of the initial complaint filed, the order resulting from the hearing and any other relevant legal documents.

26-9-217. Regulations; limitation.

(a) The commissioner may, in accordance with W.S. 26-2-110 promulgate reasonable regulations as are necessary or proper to carry out the purposes of this chapter.

(b) Repealed By Laws 2007, Ch. 43, § 1.

26-9-218. Repealed By Laws 2011, Ch. 60, § 3.

26-9-219. Adjuster's license; exception; notification.

(a) Application for license as an adjuster shall be made to the commissioner on forms he prescribes and furnishes. The commissioner shall issue the license as to qualified individuals upon payment of the license application fee stated in W.S. 26-4-101. An adjuster may qualify for a license in one (1) or more of the following lines of insurance:

(i) Property insurance, as defined in W.S. 26-5-104;

(ii) Casualty insurance, as defined in W.S. 26-5-106;

(iii) Crop insurance, as defined in W.S. 26-9-202(a)(xxi).

(b) To be licensed as an adjuster the applicant shall:

(i) Be an adult;

(ii) Be a resident of Wyoming or of another state which permits residents of Wyoming to act as adjusters in that state;

(iii) Be a full-time salaried employee of a licensed adjuster or a graduate of a recognized law school, or have had experience or special education or training in the handling of loss claims under insurance contracts of sufficient duration and extent to make him competent to fulfill the responsibilities of an adjuster;

(iv) Be trustworthy and of good reputation;

(v) Have and maintain an office accessible to the public and keep therein the usual and customary records in paper, electronic or other appropriate format, pertaining to transactions under the license;

(vi) Within one (1) year prior to submitting the application for the license, have taken and passed a written examination in a form prescribed by the commissioner. The commissioner may waive written examination of a nonresident applicant if the applicant is licensed as an adjuster in his home state, is in good standing in his home state and his home state grants this state's resident adjusters a similar privilege; and

(vii) If being licensed as a resident, have provided the commissioner fingerprints and other information and permission necessary for a criminal history record background check as provided in W.S. 7-19-201(a). The cost of the criminal history record background check shall be paid by the applicant.

(c) A Wyoming adjuster's license is required of any adjuster who by physical appearance or through electronic or other means, acts in this state on behalf of an insurer for the purpose of either investigating and negotiating settlements relative to insurance claims or applying the factual circumstances of an insurance claim to the insurance policy provisions, or both, arising under property and casualty insurance contracts, unless the loss is of an unusual, uncommon or unique nature requiring special expertise or knowledge not readily available among adjusters licensed in this state, or for the adjustment of a series of losses resulting from a catastrophe common to those losses. Any insurer on whose behalf an adjuster who is not licensed in Wyoming either investigates and negotiates settlements relative to insurance claims or applies the factual circumstances of an insurance claim to the insurance policy provisions, or both, arising under property and casualty insurance contracts, whether by physical appearance or through electronic or other means, shall notify the commissioner of such action prior to the unlicensed adjuster acting in this state.

(d) If the state in which the adjuster maintains his principal place of residency or principal place of business does not license adjusters for the line of authority being applied

for, the adjuster shall designate his home state, which may be any state in which the adjuster is licensed and in good standing and which state meets licensure requirements similar to the requirements of the state of Wyoming as determined by the commissioner.

(e) For purposes of this section, "home state" means the District of Columbia and any state or territory of the United States in which an adjuster maintains his principal place of residence or business and is licensed to act as a resident adjuster.

(f) This section shall not apply to an individual who:

(i) Collects claim information from, or furnishes claim information to, insureds or claimants for portable electronic device insurance claims;

(ii) Conducts portable electronic device insurance claim data entry, including entering data into an automated claims adjudication system; and

(iii) Is supervised by a licensed adjuster, or licensed agent who is exempt from licensure as an adjuster pursuant to W.S. 26-1-102(a)(i). The agent or adjuster shall not supervise more than twenty-five (25) persons who are exempted under this subsection.

(g) For purposes of subsection (f) of this section:

(i) "Automated claims adjudication system" means a preprogrammed computer system which is designed for the collection, data entry, calculation and initial resolution of portable electronic device insurance claims;

(ii) "Portable electronic device insurance claim" means a claim filed by an insured or claimant to receive benefits under a portable electronic device insurance contract for an electronic device and its accessories that are portable in nature and which must be easily carried or conveyed by hand.

26-9-220. Insurance consultants.

(a) No person shall be held out to the public as an insurance consultant for hire unless a license as such has been issued in accordance with this section.

(b) An application for a license to act as an insurance consultant for hire shall be made to the commissioner on forms he prescribes. The commissioner shall require that the applicant, within one (1) year prior to submitting the application for the license, have taken and passed a written examination in a form prescribed by the commissioner. The commissioner may waive written examination of a nonresident applicant if the applicant is licensed as a consultant in his home state, is in good standing in his home state and his home state grants this state's resident consultants a similar privilege. The commissioner may conduct investigations concerning the applicant's qualifications, residence, business affiliations and any other matter he deems necessary to determine compliance with this chapter or for the public's protection. The applicant shall provide the commissioner fingerprints and other information and permission necessary for a criminal history record background check as provided in W.S. 7-19-201(a). The cost of the criminal history record background check shall be paid by the applicant.

(c) The commissioner shall collect an application fee, a fee for the license, if issued, and a renewal fee, as provided in W.S. 26-4-101. No license is valid for longer than twenty-four (24) months. A license may be renewed in the same manner as an insurance producer's license.

(d) All provisions of this chapter apply to licensees under this section to the extent that they are not in conflict with this section.

(e) This section does not apply to licensed attorneys.

(f) An insurance producer who is also licensed as a consultant under this section shall not act in the dual capacity of an insurance producer and a consultant in the same insurance transaction.

26-9-221. Repealed by Laws 2017, ch. 15, § 3.

26-9-222. Repealed By Laws 2011, Ch. 60, § 3.

26-9-223. Repealed by Laws 2004, Ch. 7, § 2.

26-9-224. Scope of broker's authority; broker's commissions.

(a) Any insurance producer acting in the capacity of a broker is not an agent or other representative of an insurer and does not have power by his own acts to obligate the insurer upon any risk or by any insurance transaction.

(b) An insurer or insurance producer has the right to pay to an insurance producer acting in the capacity of a broker and licensed under this chapter the customary commissions upon insurance placed through the producer acting as a broker.

26-9-225. Broker and agent license combinations.

The sole relationship between an insurance producer acting in the capacity of a broker and an insurer as to which he is then appointed as an agent, as to transactions arising during the existence of that agency appointment, is that of insurer and agent and not that of insurer and broker.

26-9-226. "Controlled business" restrictions.

(a) The commissioner shall not grant, renew, continue or permit to exist any license as an insurance producer if he finds that the license has been or is being used principally for the purpose of writing "controlled business" as follows:

(i) Insurance on his own interests or those of his family or of his employer; or

(ii) Insurance or annuity contracts covering himself or members of his family, or the officers, directors, stockholders, partners or employees of a partnership, association or corporation of which he or a member of his family is an officer, director, stockholder, partner, associate or employee.

(b) A license is deemed to have been or intended to be used principally for the purpose of writing controlled business if the commissioner finds that during any twelve (12) month period the aggregate commissions earned from controlled business as specified in this section have exceeded or probably will exceed the aggregate commissions to be earned on other business written by an applicant or licensee during the same period.

(c) If commissions on controlled business transacted by an insurance producer payable in one (1) calendar year exceed the commissions on other insurance business transacted by the

licensee and payable in the same year, the receipt of the excess commissions is an unlawful rebate.

(d) This section does not apply to:

(i) Insurance of the interest of:

(A) A motor vehicle sales or financing agency in a motor vehicle it sells or finances;

(B) A real property mortgagee in the mortgaged property.

(ii) Credit life insurance and credit disability insurance.

26-9-227. Authority under license to transact business; nontransferability.

Any licensee under this chapter may transact business as authorized by the license throughout the state of Wyoming. No city, county or other political subdivision of this state shall require any other or further permit, registration or authority for transactions by the licensee therein.

26-9-228. Place of business of licensees; display of licenses; records.

(a) Each resident insurance producer shall have and maintain in this state a place of business accessible to the public and in which the licensee principally conducts transactions under his license. The address of the place shall appear upon the license, and the licensee shall promptly notify the commissioner in writing of any change thereof as provided by W.S. 26-9-207(f). Nothing in this section prohibits maintenance of a place of business in the licensee's residence in this state.

(b) Repealed by Laws 2022, ch. 46, § 3.

(c) The insurance producer shall keep at his place of business a complete record of transactions under his license. The record shall show, as to each insurance policy or contract placed by or through the licensee, the names of the insurer and insured, the number, expiration date of, premium payable as to the policy or contract and any other information the commissioner reasonably requires. The insurance producer shall

keep the record available for inspection for a period of at least three (3) years after completion of the transactions.

(d) The requirements of subsection (c) of this section are satisfied if the records specified in this section may be obtained immediately from a central storage place, or elsewhere by on line computer terminals located at the licensee's place of business.

26-9-229. Reporting and accounting for premiums.

(a) Any premiums or return premiums received by an insurance producer are trust funds received in a fiduciary capacity, and the producer, in the regular course of business, shall account for and pay the funds to the insured, insurer or insurance producer entitled thereto.

(b) The licensee shall establish a separate trust account for premiums specified in subsection (a) of this section and shall not use the account for or commingle it with his own funds. He shall maintain an accurate record and itemization of the funds deposited in the account.

(c) Any insurance producer who diverts or appropriates any funds, to which he is not lawfully entitled, to his own use is guilty of embezzlement and upon conviction shall be punished as provided by law.

(d) A limited lines producer for specialty limited lines shall not be required to treat monies collected from customers purchasing additional specialty limited lines insurance as funds received in a fiduciary capacity, provided that:

(i) The charges for specialty limited lines insurance coverage are itemized and ancillary to the principal business transaction; and

(ii) The insurer has consented in writing, signed by an officer of the insurer, that premiums need not be segregated from funds received by the producer for the principal business transaction.

26-9-230. Service of process on nonresident producers.

(a) Application for and acceptance of a license as a nonresident insurance producer or surplus lines broker constitutes irrevocable appointment of the commissioner as the

attorney of the licensee for the acceptance of service of process issued in this state in any action or proceeding against the licensee arising out of the licensing or any transactions under the license.

(b) Duplicate copies of process shall be served upon the commissioner or other person in apparent charge of his office during his absence, accompanied by payment to the commissioner a process fee as provided in W.S. 26-4-101. Upon receiving the service the commissioner shall promptly forward a copy thereof by registered or certified mail, with return receipt requested, to the nonresident licensee at his business address last of record with the commissioner.

(c) Process served upon the commissioner and copy thereof forwarded as provided in this section for all purposes constitutes personal service thereof upon the licensee.

26-9-231. Continuing education.

(a) Resident insurance producers, title agents licensed pursuant to W.S. 26-23-318, adjusters, nonresident adjusters not exempted under subsection (f) of this section, and other resident persons required to be licensed under this chapter shall complete twenty-four (24) classroom hours of continuing education within each two (2) year licensing period. Of the twenty-four (24) hours at least three (3) shall relate to ethical requirements. The requirements of this section do not apply to nonresident insurance producers, those persons who hold licenses for any kinds of insurance for which an examination is not required, nor shall they apply to any such limited or restricted licenses as the commissioner may exempt.

(b) Any person teaching any approved continuing education course or lecturing at any approved seminar shall qualify for the same number of classroom hours granted to the person taking the course or seminar.

(c) The commissioner may promulgate rules and regulations necessary to carry out the purposes of this section.

(d) Repealed By Laws 2004, Chapter 7, § 2.

(e) For good cause shown, the commissioner may grant an extension of up to one (1) year to complete the required continuing education.

(f) Every person subject to this section shall furnish, in a form satisfactory to the commissioner, written certification as to the courses, programs or seminars of instruction taken by that person. The certification shall be executed by or on behalf of the sponsoring organization within a fifteen (15) day period following the course, program or seminar. A nonresident adjuster having met the continuing education requirements in his home state is exempt from the provisions of this section. A nonresident adjuster not licensed in his home state is subject to the requirements of this section.

(g) Repealed by Laws 2022, ch. 46, § 4.

(h) Any person failing to submit proof required by rule of the commissioner of having met the requirements of this section and who has not been granted an extension of time within which to comply shall not have his license renewed until the person demonstrates to the satisfaction of the commissioner that he has complied with all requirements of this section.

(j) No person shall act as a continuing education provider in this state unless that person has been granted approval by the commissioner:

(i) A person applying for approval as a continuing education provider shall make application to the department on forms prescribed by the commissioner and pay the fees established in W.S. 26-4-101(a);

(ii) A continuing education provider's approval shall remain in effect unless revoked or suspended if on or before the last day of the month in which the application is approved in the second year following approval and every two (2) years thereafter the continuation fee set forth in W.S. 26-4-101(a) is paid;

(iii) Once granted approval, a continuing education provider may submit courses for approval by using forms prescribed by the commissioner and paying the fees set forth in W.S. 26-4-101(a). Course approvals shall remain in effect unless revoked or suspended if on or before the last day of the month in which the course is approved in the second year following approval and every two (2) years thereafter the continuation fees set forth in W.S. 26-4-101(a) are paid.

(k) The commissioner may make arrangements, including contracting with an outside service, for the handling of

continuing education providers and courses. If an outside service is employed, all continuing education provider applications, course approval requests and fees shall be remitted to the service provider.

26-9-232. Repealed by Laws 2022, ch. 46, § 3.

26-9-233. Assumed names.

An insurance producer doing business under any name other than the producer's legal name is required to notify the insurance commissioner prior to using the assumed name.

26-9-234. Specialty limited lines producer license.

(a) The commissioner may issue to an applicant a specialty limited lines producer license for the sale, solicitation or delivery of specialty lines insurance where the sale of the product is ancillary to the business of the person offering the product.

(b) Application under this section shall be made in accordance with W.S. 26-9-206, except business entity applicants applying for a specialty limited lines producer license shall be exempt from providing shareholders, officers and directors information. However, if the business entity derives more than fifty percent (50%) of its revenue from the sale of insurance, information shall be provided for all officers, directors and shareholders of record that have beneficial ownership of ten percent (10%) or more of any class of securities, who are subject to 15 U.S.C. 78p or subsequent similar federal enactment.

(c) An examination is not required for issuance of a specialty limited lines producer license nor is a licensee required to comply with continuing education requirements of W.S 26-9-231.

(d) A business entity licensed as a specialty limited lines producer shall keep a register of each location at which insurance is offered on the licensed business entity's behalf.

(e) A business entity licensed as a specialty limited lines producer for specialty limited lines insurance shall submit the register required in subsection (d) of this section within ten (10) days upon request of the commissioner. The

registry shall be open to inspection and examination by the commissioner.

(f) A specialty limited lines producer shall not advertise, represent or otherwise hold out the license holder or an endorsee of the license holder as an agent licensed under this chapter unless the entity or individual holds the applicable license.

(g) An endorsee of the specialty limited lines producer that offers and disseminates specialty limited lines insurance on behalf of the licensed business entity and under the direction of a specialty limited lines insurance producer is not required to be individually licensed and is eligible to offer or disseminate specialty limited lines insurance if all of the following apply:

(i) The endorsee is eighteen (18) years of age or older;

(ii) The endorsee shall have received a program of instruction or training prior to receiving permission to operate on behalf of the business entity and under the direction of the designated responsible producer. The training materials shall be made available to the commissioner upon request; and

(iii) The endorsee's compensation shall not be based primarily on the placement of the insurance product but the endorsee may receive compensation for activities under the specialty limited lines license which is incidental to their overall compensation.

(h) An endorsee's authorization to offer or disseminate specialty limited lines insurance shall expire when the endorsee's employment with or representation of the licensed entity is terminated.

(j) Individuals who offer or disseminate specialty limited lines insurance whose compensation is primarily dependent on the placement of the insurance product shall obtain a specialty limited lines insurance producer license as set forth in this section.

(k) Charges for specialty limited lines insurance may be billed and collected by a specialty limited lines producer. Any charge to the covered person for coverage that is not included in the cost associated with the purchase or lease of the covered

product or related services shall be separately itemized on the covered person's bill. If the insurance coverage is included with the purchase or lease of the covered product or related services the specialty limited lines producer shall clearly and conspicuously disclose to the covered person that the insurance coverage is included with the covered product or related services. Specialty limited lines producers that are billing and collecting these charges shall not be required to maintain these funds in a segregated account provided that the specialty limited lines producer is authorized by the insurer to hold these funds in an alternative manner. Specialty limited lines producers may receive compensation for billing and collection services.

(m) The commissioner may adopt rules necessary to implement this section.

(n) To the extent that they are not in conflict with this section, all provisions of the Wyoming Insurance Code apply to licensees under this section.

26-9-235. Licensing examination review panel.

(a) The commissioner shall review the procedures for administering examinations required by this chapter no less than every three (3) years. The review shall include consideration of employing outside testing services as authorized by W.S. 26-9-205(b).

(b) The commissioner shall establish a review panel consisting of six (6) licensed insurance producers or adjusters to assist in the administration of duties under subsection (a) of this section. Each licensed insurance producer or adjuster shall have been licensed in this state for at least three (3) years immediately prior to appointment. One (1) shall be a life and accident and health producer, one (1) a property and casualty producer, one (1) the producer of a domestic insurer, one (1) a title insurance agent, one (1) a limited lines producer and one (1) an insurance adjuster.

(c) Panel members shall serve four (4) year terms, except that of the initial review panel three (3) members shall serve a term of two (2) years and three (3) members for four (4) years. Initial terms shall commence on August 1, 2017. Any member of the review panel may be removed as provided under W.S. 9-1-202. Vacancies shall be filled by the commissioner for the unexpired term.

(d) The review panel shall provide the following assistance to the commissioner:

(i) Review general policy concerning the scope, contents, procedure and conduct of examinations to be given by the commissioner for licenses for insurance producers and adjusters;

(ii) Review the questions comprising each particular examination;

(iii) Review the scope and contents of material furnished examination applicants by the commissioner under W.S. 26-9-205 for the purpose of preparing for an examination;

(iv) Review the procedure to be followed in the conduct of examinations, including but not limited to application for examination, frequency and place of examinations and monitoring and safeguarding of examination questions and papers;

(v) Review the value to be allowed for a correct answer to each question in examination grading;

(vi) Make any recommendations to the commissioner it deems appropriate, including recommendations regarding the administration of the examination requirements for licensing.

(e) The commissioner, upon application by the panel members, is authorized to reimburse each panel member per diem and mileage expenses, as allowed to state employees, for each day they are actually engaged in the discharge of the panel's duty.

CHAPTER 10 - STATE BOARD OF INSURANCE AGENT EXAMINERS

26-10-101. Repealed by Laws 2017, ch. 9, § 3.

26-10-102. Repealed by Laws 2017, ch. 9, § 3.

26-10-103. Repealed by Laws 2017, ch. 9, § 3.

26-10-104. Repealed by Laws 2017, ch. 9, § 3.

26-10-105. Repealed by Laws 2017, ch. 9, § 3.

26-10-106. Repealed by Laws 2017, ch. 9, § 3.

26-10-107. Repealed by Laws 2017, ch. 9, § 3.

26-10-108. Repealed by Laws 2017, ch. 9, § 3.

26-10-109. Repealed by Laws 2017, ch. 9, § 3.

CHAPTER 11 - NONADMITTED INSURANCE

26-11-101. Short title.

This chapter constitutes and may be cited as the "Nonadmitted Insurance Law".

26-11-102. Home state regulation of nonadmitted insurance; exemptions.

(a) This chapter does not apply to reinsurance or to the following insurances when placed by licensed insurance producers or surplus lines brokers of this state or when procured directly by an insured from a nonadmitted insurer:

(i) Wet marine and transportation insurance;

(ii) Repealed by Laws 2020, ch. 45, § 2.

(iii) Insurance on operations of railroads engaged in transportation in interstate commerce and their property used in those operations;

(iv) Insurance on aircraft owned or operated by manufacturers of aircraft, or on aircraft operated in commercial interstate flight, or cargo of that aircraft, or against liability, other than worker's compensation and employer's liability, arising out of the ownership, maintenance or use of that aircraft.

(b) The placement of nonadmitted insurance shall be subject to the statutory and regulatory requirements solely of the insured's home state.

(c) This section shall not be construed to preempt any state law, rule or regulation that restricts the placement of workers' compensation insurance or excess insurance for self-funded workers' compensation plans with a nonadmitted insurer.

26-11-103. Definitions.

(a) As used in this chapter:

(i) "Admitted insurer" means an insurer authorized to transact the business of insurance in this state;

(ii) Repealed by Laws 2020, ch. 45, § 2.

(iii) "Export" means to place surplus lines insurance with a nonadmitted insurer;

(iv) "Home state" means as follows:

(A) Except as provided in subparagraphs (B) and (C) of this paragraph, "home state" means, with respect to an insured:

(I) The state in which an insured maintains its principal place of business or, in the case of an individual, the individual's principal residence; or

(II) If one hundred percent (100%) of the insured risk is located out of the state referred to in subdivision (I) of this subparagraph, the state to which the greatest percentage of the insured's taxable premium for that insurance contract is allocated.

(B) If more than one (1) insured from an affiliated group are named insureds on a single nonadmitted insurance contract, the term "home state" means the home state, as determined pursuant to subparagraph (A) of this paragraph, of the member of the affiliated group that has the largest percentage of premium attributed to it under the insurance contract;

(C) When a group policyholder pays one hundred percent (100%) of the premium from its own funds, the term "home state" means the home state, as determined pursuant to subparagraph (A) of this paragraph, of the group policyholder. When a group policyholder does not pay one hundred percent (100%) of the premium from its own funds, the term "home state" means the home state, as determined pursuant to subparagraph (A) of this paragraph, of the group member.

(v) "Nonadmitted insurance" means any property and casualty, accident and health or sickness or disability

insurance permitted to be placed directly or through a surplus lines broker with a nonadmitted insurer eligible to accept the insurance;

(vi) "Reciprocal state" means a state that has:

(A) Entered into a nonadmitted insurance compact; or

(B) Otherwise adopted the allocation schedule and reporting forms prescribed by a multistate agreement for nonadmitted insurance.

(vii) "Recognized financial institution" means an institution that is organized or licensed under the laws of the United States or any state and is insured by the federal deposit insurance corporation;

(viii) "Affiliate" means with respect to an insured, any entity that controls, is controlled by or is under common control with the insured;

(ix) "Affiliated group" means any group of entities that are all affiliated;

(x) "Business entity" means a corporation, association, partnership, limited liability company, limited liability partnership or any other legal entity;

(xi) "Control" means an entity has "control" over another entity if:

(A) The entity directly or indirectly or acting through one (1) or more other persons owns, controls or has the power to vote twenty-five percent (25%) or more of any class of voting securities of the entity; or

(B) The entity controls in any manner the election of a majority of directors or trustees of the other entity.

(xii) "Independently procured insurance" means insurance procured directly by an insured from an eligible nonadmitted insurer;

(xiii) "Kind of insurance" means one (1) of the types of insurance required to be reported in the annual statement which is filed with the commissioner by admitted insurers;

(xiv) "Nonadmitted insurer" means with respect to a state, an insurer not authorized to transact the business of insurance in the state, but does not include a health maintenance organization or a risk retention group as that term is defined in section 2(a)(4) of the Liability Risk Retention Act of 1986, 15 U.S.C. 3901(a)(4);

(xv) "Premium tax" means with respect to surplus lines or independently procured insurance coverage, any tax, fee, assessment or other charge imposed by a government entity directly or indirectly based on any payment made as consideration for an insurance contract for such insurance, including premium deposits, assessments, registration fees and any other compensation given in consideration for a contract of insurance;

(xvi) "Principal place of business" means with respect to determining the home state of the insured:

(A) The state where the insured maintains its headquarters and where the insured's high-level officers direct, control and coordinate the business' activities;

(B) If the insured's high-level officers direct, control and coordinate the business' activities in more than one (1) state, the state in which the greatest percentage of the insured's taxable premium for that insurance contract is allocated; or

(C) If the insured maintains its headquarters or the insured's high-level officers direct, control and coordinate the business activities outside of any state, the state to which the greatest percentage of the insured's taxable premium for that insurance contract is allocated.

(xvii) "Principal place of residence" means with respect to determining the home state of the insured:

(A) The state where the insured resides for the greatest number of days during a calendar year; or

(B) If the insured's principal residence is located outside any state, the state to which the greatest

percentage of the insured's taxable premium for that insurance contract is allocated.

(xviii) "Qualified risk manager" means with respect to a policyholder of commercial insurance, a person who meets all of the requirements set forth by department rule and regulation, which requirements shall be in compliance with the Nonadmitted and Reinsurance Reform Act of 2010 or subsequent similar federal enactment;

(xix) "Surplus lines broker" means an individual or business entity which is licensed in a state to sell, solicit or negotiate insurance with nonadmitted insurers;

(xx) "Type of insurance" means coverage afforded under the particular policy that is being placed;

(xxi) "Wet marine and transportation insurance" means:

(A) Insurance upon vessels, crafts, hulls and other interests in them or with relation to them;

(B) Insurance of marine builder's risks, marine war risks and contracts of marine protection and indemnity insurance;

(C) Insurance of freight and disbursements pertaining to a subject of insurance within the scope of this subsection; and

(D) Insurance of personal property and interests therein, in the course of exportation from or importation into any country, or in the course of transportation coastwise or on inland waters, including transportation by land, water or air from point of origin to final destination, in connection with any and all risks or perils of navigation, transit or transportation, and while being prepared for and while awaiting shipment, and during any incidental delays, transshipment or reshipment, provided, however, that insurance of personal property and interests therein shall not be considered wet marine and transportation insurance if the property has:

(I) Been transported solely by land;

(II) Reached its final destination as specified in the bill of lading or other shipping document; or

(III) The insured no longer has an insurable interest in the property.

26-11-104. Conditions for export.

(a) If certain insurance coverages cannot be procured from admitted insurers, those coverages, designated in this chapter as "surplus lines", may be procured from nonadmitted insurers, subject to the following conditions:

(i) The insurance shall be procured through a licensed surplus lines broker;

(ii) The full amount of insurance required is not procurable, after diligent effort has been made by the insurance producer to do so, from among the admitted insurers authorized to transact and actually writing that kind and type of insurance in this state, and the amount of insurance exported shall be only the excess over the amount procurable from admitted insurers. The surplus lines broker shall verify that a properly conducted diligent effort search was performed and documented as prescribed by the commissioner;

(iii) The insurance shall not be exported for the purpose of securing advantages either as to:

(A) A lower premium rate than would be accepted by an admitted insurer; or

(B) Terms of the insurance contract.

(iv) The insurer is an eligible nonadmitted insurer;

(v) The insurer is authorized to write the kind of insurance in its domiciliary jurisdiction;

(vi) All other requirements of this chapter are met.

(b) A surplus lines broker is not required to make a diligent effort search to determine whether the full amount or type of insurance can be obtained from admitted insurers when the broker is seeking to procure or place nonadmitted insurance for an exempt commercial purchaser provided:

(i) The broker procuring or placing the surplus lines insurance has disclosed to the exempt commercial purchaser that

such insurance may or may not be available from the admitted market that may provide greater protection with more regulatory oversight; and

(ii) The exempt commercial purchaser has subsequently requested in writing for the broker to procure or place such insurance from a nonadmitted insurer.

(c) For purposes of this section, the term "exempt commercial purchaser" means any person purchasing commercial insurance that, at the time of placement, meets the following requirements:

(i) The person employs or retains a qualified risk manager to negotiate insurance coverage;

(ii) The person has paid aggregate nationwide commercial property and casualty insurance premiums in excess of one hundred thousand dollars ($100,000.00) in the immediately preceding twelve (12) months;

(iii) The person meets at least one (1) of the following criteria:

(A) The person possesses a net worth in excess of twenty million dollars ($20,000,000.00) as adjusted pursuant to paragraph (iv) of this subsection;

(B) The person generates annual revenues in excess of fifty million dollars ($50,000,000.00) as adjusted pursuant to paragraph (iv) of this subsection;

(C) The person employs more than five hundred (500) full-time or full-time equivalent employees per individual insured or is a member of an affiliated group employing more than one thousand (1,000) employees in the aggregate;

(D) The person is a not-for-profit organization or public entity generating annual budgeted expenditures of at least thirty million dollars ($30,000,000.00) as adjusted pursuant to paragraph (iv) of this subsection;

(E) The person is a municipality with a population in excess of fifty thousand (50,000) individuals.

(iv) Effective on January 1, 2015 and every five (5) years thereafter, the amounts in subparagraphs (A), (B) and (D)

of paragraph (iii) of this subsection shall be adjusted to reflect the percentage change for such five (5) year period in the consumer price index for all urban consumers published by the bureau of labor statistics of the United States department of labor.

26-11-105. Surplus lines transaction report.

(a) Within forty-five (45) days after placing any surplus line insurance for an insured whose home state is this state, each surplus lines broker shall execute and file a report regarding the insurance coverage which shall be kept confidential by the commissioner, including the following:

(i) The name and address of the insured;

(ii) The identity of the insurer or insurers;

(iii) A description of the subject and location of the risk;

(iv) The amount of premium charged for the insurance;

(v) Tax allocation information detailing the portion of the premium attributable to properties, risks or exposures located in each state; and

(vi) Any other information as may be required by the commissioner.

(b) The report shall be in the form and manner prescribed by the commissioner.

26-11-106. Open lines for export.

(a) The commissioner, by order, may declare eligible for export generally and without compliance with W.S. 26-11-104(a)(ii) and (iii), any type of insurance coverage or risk for which he finds, after notice and a hearing, that there is not a reasonable or adequate market among admitted insurers either as to acceptance of the risk, contract terms, premium or premium rate. The order shall continue in effect during the existence of the conditions upon which predicated, but subject to the commissioner's earlier termination.

(b) Repealed by Laws 2020, ch. 45, § 2.

(c) Repealed by Laws 2020, ch. 45, § 2.

26-11-107. Requirements for eligible nonadmitted insurers; publication of eligible insurers.

(a) Repealed By Laws 2012, Ch. 37, § 3.

(b) Repealed By Laws 2012, Ch. 37, § 3.

(c) The commissioner may issue an order of ineligibility if he finds or has reason to believe that the insurer:

(i) Does not meet the requirements of this section;

(ii) Has without just cause refused to pay claims arising under its contracts in the United States; or

(iii) Has otherwise conducted its affairs in such manner as to result in or threaten injury or loss to the insuring public of the United States.

(d) The commissioner may create and maintain a list of all nonadmitted insurers that qualify as eligible nonadmitted insurers in Wyoming. To qualify for inclusion on the list, the nonadmitted insurer shall annually file an application with the commissioner and any other appropriate information as required by the commissioner. This subsection does not obligate the commissioner to determine the actual financial condition or claims practices of any nonadmitted insurer. The status of eligibility, if granted by the commissioner, indicates only that the insurer appears to be sound financially and to have satisfactory claims practices, and that the commissioner has no credible evidence to the contrary. While any such list is in effect the surplus lines broker shall restrict to the insurers listed all surplus line business he places.

(e) A surplus lines broker shall not place coverage with a nonadmitted insurer unless, at the time of placement, the surplus lines broker has determined that the nonadmitted insurer is eligible under this section.

(f) A nonadmitted insurer eligible to place surplus lines insurance or independently procured insurance shall:

(i) Be authorized to write the kind of insurance in its domiciliary jurisdiction;

(ii) Have established satisfactory evidence of good repute and financial integrity; and

(iii) Be qualified under one (1) of the following subparagraphs:

(A) Have capital and surplus or its equivalent under the laws of its domiciliary jurisdiction which equals the greater of:

(I) The minimum capital and surplus requirements under the law of this state; or

(II) Fifteen million dollars ($15,000,000.00).

(B) The requirements of subparagraph (A) of this paragraph may be satisfied by an insurer's possessing less than the minimum capital and surplus upon an affirmative finding of acceptability by the commissioner. The finding shall be based upon such factors as quality of management, capital and surplus of any parent company, company underwriting profit and investment income trends, market availability and company record and reputation within the industry. In no event shall the commissioner make an affirmative finding of acceptability when the nonadmitted insurer's capital and surplus is less than four million five hundred thousand dollars ($4,500,000.00);

(iv) For an insurer not domiciled in the United States or its territories, the insurer is listed on the quarterly listing of alien insurers maintained by the NAIC international insurers department.

(g) The commissioner is authorized to enter into a cooperative agreement or interstate agreement or compact to establish additional and alternative nationwide uniform eligibility requirements that shall be applicable to nonadmitted insurers domiciled in another state or territory of the United States.

(h) Insurance policy rate and form filings applicable to admitted insurers do not apply to nonadmitted insurers issuing policies under the provisions of this chapter.

26-11-108. Evidence of surplus lines insurance.

(a) Upon placing surplus lines insurance coverage, the surplus lines broker shall promptly issue and deliver to the insured or the producer the policy, or if the policy is not then available, a certificate as described in subsection (f) of this section, cover note, binder or other evidence of the insurance. The certificate described in subsection (f) of this section, cover note, binder or other evidence of insurance shall be executed by the broker and shall show the description and location of the subject of the insurance, coverages including any material limitations other than those in standard forms, a general description of the coverages of the insurance, the premium and rate charged, taxes to be collected from the insured, the name and address of the insured and surplus lines insurer or insurers and the proportion of the entire risk assumed by each and the name and license number of the surplus lines broker.

(b) No broker shall issue or deliver any evidence of insurance or purport to insure or represent that insurance will be or has been written by any nonadmitted insurer, unless the broker has:

(i) The insurer's prior written authority for the insurance;

(ii) Received information from the insurer in the regular course of business that the insurance has been granted; or

(iii) Received an insurance policy specifying the insurer has actually issued the insurance and delivered it to the insured.

(c) If after the issuance and delivery of any evidence of insurance there is any change as to the insurer's identity, or the proportion of the risk assumed by any insurer or any other material change in coverage as stated in the surplus lines broker's original evidence of insurance or in any other material as to the insurance coverage so evidenced, the surplus lines broker shall promptly issue and deliver to the insured or the original producer an appropriate substitute for, or endorsement of the original document, accurately showing the current status of the coverage and the insurers responsible for the coverage.

(d) Repealed By Laws 2012, Ch. 37, § 3.

(e) Any surplus lines broker who knowingly or negligently issues a false certificate or other evidence of insurance, or who fails promptly to notify the insured of any material change with respect to the insurance by delivery to the insured of a substitute certificate, cover note, binder or other evidence of insurance as provided in subsection (c) of this section, upon conviction, is subject to the penalty provided by W.S. 26-1-107 or to any greater applicable penalty otherwise provided by law.

(f) As soon as reasonably possible after the placement of the insurance, the surplus lines broker shall deliver a copy of the policy or, if not available, a certificate of insurance to the insured or producer to replace any evidence of insurance previously issued. Each certificate or policy of insurance shall contain or have attached a complete record of all policy insuring agreements, conditions, exclusions, clauses, endorsements or any other material facts that would regularly be included in the policy.

26-11-109. Required information on surplus lines contracts; duty to notify insured.

(a) Every new or renewed insurance contract, certificate, cover note or other confirmation of insurance that is procured and delivered as a surplus lines coverage pursuant to this chapter shall have stamped or printed upon it, in at least ten (10) point bold type font, the name and address of the surplus lines broker who procured the coverage, and the following disclosure: "This insurance contract is issued pursuant to the Wyoming Nonadmitted Insurance Laws by an insurer neither licensed by nor under the jurisdiction of the Wyoming Insurance Department. In the event of insolvency of the surplus lines insurer, losses will not be paid by the Wyoming Insurance Guaranty Association or the Wyoming Life and Health Insurance Guaranty Association."

(b) The insurance producer shall give written notice to every person applying for insurance with a nonadmitted insurer prior to placement. The notice shall provide the disclosure required by subsection (a) of this section and any additional information required by the commissioner. The applicant shall sign and date a copy of the notice acknowledging receipt. The notice shall be in a form acceptable to the commissioner, a signed copy of which shall be maintained by the surplus lines broker with the records of the contract and available for examination by the commissioner.

(i) Repealed by Laws 2020, ch. 45, § 2.

(ii) Repealed by Laws 2020, ch. 45, § 2.

(c) Nothing herein contained shall nullify any agreement by any insurer to provide insurance.

26-11-110. Enforceability and validity of nonadmitted insurance.

Insurance contracts procured from nonadmitted insurers in accordance with this chapter are fully valid and enforceable as to all parties and shall be given recognition in all matters and respects to the same effect as like contracts issued by admitted insurers.

26-11-111. Liability of insurer as to losses and unearned premiums; applicability of section to insurers.

(a) As to a surplus line risk which is assumed by a nonadmitted insurer pursuant to this chapter, and if the premium thereon is received by the surplus line broker who placed the insurance, in all questions thereafter arising under the coverage as between the insurer and the insured the insurer is deemed to have received the premium due to it for that coverage. The insurer is liable to the insured for losses covered by the insurance and for unearned premiums which are payable to the insured upon cancellation of the insurance, whether or not the broker is indebted to the insurer with respect to the insurance or for any other cause.

(b) Each nonadmitted insurer assuming a surplus line risk under this chapter subjects itself to the terms of this section.

26-11-112. Surplus lines broker's license; authority for issuance; application; fee; applicable law.

(a) Repealed By Laws 2012, Ch. 37, § 3.

(b) Repealed By Laws 2012, Ch. 37, § 3.

(c) Repealed By Laws 2012, Ch. 37, § 3.

(d) Repealed By Laws 2012, Ch. 37, § 3.

(e) For insureds whose home state is Wyoming, a person shall not procure a contract of surplus lines insurance for the

insured with a nonadmitted insurer unless the person possesses a current surplus lines insurance license issued by the commissioner.

(f) The commissioner may issue a resident surplus lines broker license to a qualified holder of a current property and casualty producer license if:

(i) The person has paid the fees set forth in W.S. 26-4-101(a);

(ii) The person has submitted or transmitted to the commissioner a completed uniform application;

(iii) The individual has taken and passed a written examination in a form prescribed by the commissioner; and

(iv) The person has established and continues to maintain an office in this state.

(g) A nonresident person shall receive a nonresident surplus lines broker license pursuant to the requirements of W.S. 26-9-208.

(h) A business entity acting as a surplus lines broker is required to obtain a surplus lines broker license. In addition to the requirements for licensure set forth in subsections (f) and (g) of this section; before approving the application the commissioner shall find that the business entity has designated a licensed surplus lines broker responsible for the business entity's compliance with the insurance laws, rules and regulations of this state.

(j) The commissioner may require any documents reasonably necessary to verify the information contained in an application.

(k) The commissioner shall waive any requirements for a nonresident surplus lines license applicant with a valid license from his home state, except the requirements imposed by this section, if the applicant's home state awards nonresident surplus lines licenses to residents of this state on the same basis.

(m) Repealed by Laws 2019, ch. 19, § 2.

(n) The license and licensee are subject to chapter 9 of this title as provided in W.S. 26-9-201.

26-11-113. Surplus lines broker's license; suspension or revocation; grounds; procedure.

(a) The commissioner may, after appropriate notice and opportunity for hearing pursuant to the Wyoming Administrative Procedure Act and in accordance with W.S. 26-2-125 through 26-2-129, place on probation, suspend, revoke or refuse to issue or renew any surplus lines broker's license or other license issued under this title, or may levy a civil penalty in accordance with W.S. 26-1-107 or any combination of actions for any one (1) or more of the following causes:

(i) Repealed By Laws 2012, Ch. 37, § 3.

(ii) Repealed By Laws 2012, Ch. 37, § 3.

(iii) Removal of the resident surplus lines broker's office from this state;

(iv) Removal of the resident surplus lines broker's office accounts and records from this state during the period during which the accounts and records are required to be maintained under W.S. 26-11-116;

(v) Failure to make and file required reports when due;

(vi) Failure to remit the tax on surplus lines premiums as provided in this chapter;

(vii) Failure to maintain a bond as required by W.S. 26-11-114;

(viii) Violation of any provision of this chapter; or

(ix) For any cause for which an insurance license could be denied, revoked, suspended or renewal refused under chapter 9 of this title.

(b) The procedures provided by chapter 9 of this code for suspension or revocation of licenses apply to suspension or revocation of a surplus line broker's license.

(c) Upon suspending or revoking the broker's surplus line license, the commissioner shall also suspend or revoke all other licenses of or as to the same individual under this code.

(d) No broker whose license is suspended or revoked shall again be licensed until any fines or delinquent taxes he owes are paid, or, in case of revocation, until after expiration of one (1) year from the date revocation is final.

26-11-114. Surplus line broker's bond.

Prior to issuance of a license as a surplus line broker, the applicant shall file with the commissioner and thereafter for as long as the license remains in effect shall keep in force a bond in favor of the state of Wyoming in the penal sum of ten thousand dollars ($10,000.00), with an authorized corporate surety the commissioner approves, conditioned that he will conduct business under the license in accordance with this chapter and that he will promptly remit the taxes provided by W.S. 26-11-118. The aggregate liability of the surety for any claims on the bond shall not exceed the penal sum of the bond. The bond shall not be terminated unless not less than thirty (30) days prior written notice thereof is given to the licensee and filed with the commissioner.

26-11-115. Surplus lines broker may accept and place business from producers.

A licensed surplus lines broker may accept and place surplus line business for any insurance producer licensed in this state for the kind of insurance involved and may compensate the producer therefor.

26-11-116. Records of broker; contents; examination.

(a) Each surplus lines broker shall keep in his office a full and true record of each surplus lines insurance contract placed by or through the broker for which this state is the home state of the insured, including a copy of the policy, certificate, cover note or other evidence of insurance showing each of the following applicable items:

(i) Amount of the insurance, risks and perils insured;

(ii) Gross premium charged;

(iii) Return premium paid, if any;

(iv) Rate of premium charged upon the several items of property;

(v) Effective date of contract and the terms thereof;

(vi) Name and address of each insurer on the direct risk and the proportion of the entire risk assumed by each insurer if less than the entire risk;

(vii) Name and address of the insured;

(viii) Brief general description of the property or risk insured and where located or to be performed;

(ix) Repealed By Laws 2012, Ch. 37, § 3.

(x) Amount of tax and other sums to be collected from the insured;

(xi) Allocation of taxes by state as referred to in W.S. 26-11-118;

(xii) Identity of the producer, any confirming correspondence from the insurer or its representative, and the application; and

(xiii) Any other information the commissioner requires.

(b) The record of each contract shall be kept open at all reasonable times to examination by the commissioner without notice for a period of not less than five (5) years following termination of the contract. In lieu of maintaining offices in this state, each nonresident surplus lines broker shall make available to the commissioner any and all records that the commissioner deems necessary for examination.

26-11-117. Surplus lines broker affidavit report.

(a) Each surplus lines broker, on or before February 15, May 15, August 15 and November 15 of each year, if applicable, shall file with the commissioner an affidavit report verifying that all surplus lines insurance transacted during the preceding calendar quarter has been submitted as required by the commissioner.

(b) The affidavit report of the surplus lines broker shall be in the form and manner the commissioner prescribes. The report shall include a statement as to the diligent efforts made to place the coverage with admitted insurers, the results thereof and any additional information required by the commissioner.

(i) Repealed By Laws 2011, ch. 129, § 207.

(ii) Repealed By Laws 2020, ch. 45, § 2.

(iii) Repealed By Laws 2020, ch. 45, § 2.

(iv) Repealed By Laws 2020, ch. 45, § 2.

(v) Repealed By Laws 2020, ch. 45, § 2.

(vi) Repealed By Laws 2020, ch. 45, § 2.

(vii) Repealed By Laws 2020, ch. 45, § 2.

(c) An alternative reporting and tax payment period may be required by participation in a multistate compact, reciprocal agreement or clearinghouse pursuant to W.S. 26-11-123.

(d) Repealed by Laws 2020, ch. 45, § 2.

26-11-118. Tax on surplus lines.

(a) Repealed By Laws 2011, Ch. 103, § 3.

(b) Repealed By Laws 2011, Ch. 103, § 3.

(c) In addition to the full amount of gross premiums charged by the insurer for the insurance, every surplus lines broker shall collect and pay to the commissioner a sum equal to three percent (3%) of the gross premiums charged, less any return premiums, for surplus lines insurance provided by the surplus lines broker. Where the insurance covers properties, risks or exposures located or to be performed both in and out of Wyoming, the sum payable shall be computed based on:

(i) An amount equal to three percent (3%) on that portion of the gross premiums allocated to this state; plus

(ii) An amount equal to the portion of the premiums allocated to other states or territories on the basis of the tax

rates and fees applicable to other properties, risks or exposures located or to be performed outside of Wyoming; less

(iii) The amount of gross premiums allocated to this state and returned to the insured.

(d) The tax on any portion of the premium unearned at termination of insurance having been credited by the state to the surplus lines broker shall be returned to the policyholder directly by the surplus lines broker. The surplus lines broker is prohibited from rebating, for any reason, any part of the tax.

(e) At the time of filing an affidavit report required by W.S. 26-11-117, each surplus lines broker shall pay the premium tax due for each calendar quarter's business as reported, in the manner prescribed by the commissioner. An alternative reporting and payment period may be required by participation in a multistate compact, reciprocal agreement or clearinghouse pursuant to subsection (g) of this section. The surplus lines broker shall pay interest on the amount of any delinquent tax due, at the rate of nine percent (9%) per year, compounded annually, beginning the day the amount becomes delinquent.

(f) If a surplus lines policy procured through a surplus lines broker covers properties, risks or exposures only partially located or to be performed in Wyoming, the tax due shall be computed on the portions of the premiums which are attributable to the properties, risks or exposures located or to be performed in this state. In determining the amount of premiums taxable in Wyoming, all premiums written, procured or received in Wyoming shall be considered written on properties, risks or exposures located or to be performed in Wyoming, except premiums which are properly allocated or apportioned and reported as taxable premiums of a reciprocal state.

(g) The commissioner may participate in a multistate compact, reciprocal agreement or clearinghouse with other states for the purpose of collecting, allocating and disbursing any funds collected pursuant to subsection (c) of this section. To the extent that other states where portions of the properties, risks or exposures reside have failed to enter into a compact or reciprocal allocation procedure with Wyoming, the net premium tax collected shall be retained by this state.

(h) The commissioner is authorized to utilize the allocation schedule included in the nonadmitted insurance

multistate agreement for the purpose of allocating risk and computing the tax due on the portion of premium attributable to each risk classification and to each state where properties, risks or exposures are located.

(j) The clearinghouse is authorized to collect from the surplus lines broker a reasonable service fee, as approved by the commissioner, as a percentage of total gross premiums of each surplus lines policy or document reported under this chapter to cover the cost of administrative services of the clearinghouse. The service fee shall be paid by the insured.

26-11-119. Failure to file report or pay tax; penalty.

Any licensed surplus lines broker or insured who independently procures insurance, who fails to file a report in the form and within the time required or provided for in W.S. 26-11-117 or 26-11-124 may be fined up to twenty-five dollars ($25.00) per day for each day the delinquency continues, beginning the day after the report was due until the date the report is received. The surplus lines broker or insured who independently procures insurance shall pay interest on the amount of any delinquent tax due as required by W.S. 26-11-118(e).

26-11-120. Service of process against nonadmitted insurer.

(a) A nonadmitted insurer shall be sued, upon any cause of action arising in this state under any contract it issues as a nonadmitted insurance contract pursuant to this chapter, in the district court of the county in which the cause of action arises.

(b) Legal process against the insurer in any action specified in subsection (a) of this section may be served upon the commissioner as provided in W.S. 26-3-122. The commissioner shall immediately mail a copy of the process served to the person the insurer designates in the policy for that purpose, by prepaid registered or certified mail with return receipt requested. After service of process upon the commissioner in accordance with this section, the court has jurisdiction in personam of the insurer.

(c) A nonadmitted insurer issuing a policy is deemed to have authorized service of process against it in the manner and to the effect provided in this section. The policy shall contain a provision stating the substance of this section and

designating the person to whom the commissioner shall mail process as provided in subsection (b) of this section.

26-11-121. Rules and regulations.

(a) The commissioner shall make or may approve and adopt reasonable rules and regulations, consistent with this chapter, for any of the following purposes:

(i) Carrying out of this chapter;

(ii) Establishment of procedures through which eligibility of particular proposed coverages for export is determined; and

(iii) Establishment, procedures and operations of any voluntary organization of brokers or others designed to assist those brokers to comply with this chapter.

(b) The rules and regulations are subject to the procedures and carry the penalty provided by W.S. 26-2-110.

26-11-122. Disclosure to commissioner of insurance placed with nonadmitted insurer.

Any person for whom insurance is placed with an nonadmitted insurer, upon the commissioner's order, shall produce for his examination all policies and other documents evidencing the insurance and shall disclose to the commissioner the amount of gross premiums paid or agreed to be paid for the insurance. If the person refuses to obey the commissioner's order, he is subject to the penalties provided by W.S. 26-1-107 for each refusal.

26-11-123. Interstate insurance regulatory cooperation.

To carry out the purposes of the Nonadmitted and Reinsurance Reform Act of 2010, 15 U.S.C. 8201 et seq., the commissioner may participate in a nonadmitted insurance multistate agreement or compact for the purposes of collecting, allocating and disbursing premium taxes attributable to the placement of nonadmitted insurance, providing for uniform methods of allocation and reporting among nonadmitted insurance risk classifications, sharing information among states relating to nonadmitted insurance premium taxes and providing for the determination of recommended uniform eligibility standards for nonadmitted insurers.

26-11-124. Independently procured insurance; duty to report and pay tax.

(a) Each insured whose home state is this state and who independently procures, continues or renews insurance with a nonadmitted insurer, other than insurance procured through a surplus lines broker, shall, within forty-five (45) days after the date the insurance was so procured, continued or renewed, file a report with the commissioner, in the form and manner prescribed by the commissioner, showing the name and address of the insured or insureds, name and address of the insurer, the subject of insurance, a general description of the coverage, the amount of premium currently charged and additional pertinent information requested by the commissioner.

(b) The insured is subject to the same tax and clearinghouse service fee payment requirements as apply to a surplus lines broker in W.S. 26-11-118.

(c) This section does not abrogate or modify, and shall not be construed or deemed to abrogate or modify any other provision of this chapter.

(d) This section does not authorize independent procurement of accident and health or sickness or disability insurance.

CHAPTER 12 - UNAUTHORIZED INSURERS - PROHIBITIONS, PROCESS AND ADVERTISING

ARTICLE 1 - GENERAL PROVISIONS

26-12-101. "Industrial insured" defined.

(a) As used in this chapter:

(i) "Industrial insured" means an insured:

(A) Which procures the insurance of any risk other than life and annuity contracts through 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 ($25,000.00); and

(C) Which has at least twenty-five (25) full-time employees.

26-12-102. Representing or aiding unauthorized insurers prohibited; exceptions.

(a) No person in this state shall:

(i) Act as agent for, or otherwise represent or aid on behalf of another, any insurer not then authorized to transact insurance in this state, in the:

(A) Solicitation, negotiation, procurement or carrying out of insurance or annuity contracts or the renewal thereof;

(B) Forwarding of applications for insurance;

(C) Dissemination of information as to coverage or rates;

(D) Inspection of risks;

(E) Fixing of rates;

(F) Investigation or adjustment of claims or losses; or

(G) Collection or forwarding of premiums.

(ii) In any other manner represent or assist that insurer in transacting insurance with respect to subjects of insurance resident, located or to be performed in this state.

(b) This section does not apply to:

(i) Matters the commissioner authorizes under W.S. 26-12-201 through 26-12-206;

(ii) Surplus lines insurance and other transactions for which the insurer is not required to have a certificate of authority pursuant to W.S. 26-3-102;

(iii) A licensed adjuster or attorney-at-law representing an unauthorized insurer in his professional capacity;

(iv) Persons in this state compensated solely by salary, who secure and furnish information for the purpose of enrolling individuals in, or issuing certificates under, or otherwise assisting in administering group life, group or blanket disability or annuity contracts lawfully solicited, issued and delivered in and pursuant to the laws of a state in which the insurer is authorized to transact business;

(v) Transactions in this state involving contracts of insurance issued to one (1) or more industrial insureds.

26-12-103. Suits by unauthorized insurers prohibited.

As to transactions not permitted under W.S. 26-3-102, no unauthorized insurer shall institute or file or cause to be instituted or filed, any suit, action or proceeding in this state to enforce any right, claim or demand arising out of any insurance transaction in this state, until the insurer obtains a certificate of authority to transact that insurance in this state.

ARTICLE 2 - UNAUTHORIZED INSURERS PROCESS ACT

26-12-201. Short title; interpretation of article.

(a) This article constitutes and may be cited as the "Unauthorized Insurers Process Act".

(b) This article shall be so interpreted as to carry out its general purpose to make uniform the laws of those states which enact it.

26-12-202. Commissioner as agent for service.

(a) Solicitation, carrying out or delivery of any insurance contract, by mail or otherwise, within this state by an unauthorized insurer, or the performance within this state of any other service or transaction connected with insurance by or on behalf of the insurer:

(i) Constitutes the insurer's appointment of the commissioner and his successors in office as its attorney, upon whom may be served all lawful process issued within this state

in any action or proceeding against the insurer arising out of any such contract or transaction; and

(ii) Signifies the insurer's agreement that any such service of process has the same legal effect and validity as personal service of process upon it in this state.

26-12-203. Service of process generally.

(a) Service of process upon any insurer pursuant to W.S. 26-12-202 shall be made in accordance with W.S. 26-3-122, and service of process is sufficient if it complies with that section.

(b) Service of process in any such action, suit or proceeding, in addition to the manner provided in subsection (a) of this section, is valid if:

(i) Served upon any person within this state, who in this state on behalf of the insurer, is:

(A) Soliciting insurance;

(B) Making any contract of insurance or issuing or delivering any policies or written contracts of insurance; or

(C) Collecting or receiving any premium for insurance; and

(ii) Otherwise complies with W.S. 26-3-122(d).

(c) No plaintiff or complainant is entitled to a judgment by default under this section until the expiration of thirty (30) days from the date of the filing of the affidavit of compliance.

(d) Nothing in this section limits or abridges the right to serve any process, notice or demand upon any insurer in any other manner permitted by law.

26-12-204. Exemptions from service of process provisions.

(a) W.S. 26-12-202 and 26-12-203 do not apply to surplus line insurance lawfully carried out under chapter 11, or to reinsurance, or to any action or proceeding against an unauthorized insurer arising out of any of the following if the policy or contract contains a provision designating the

commissioner as its attorney for the acceptance of service of lawful process in any action or proceeding instituted by or on behalf of an insured or beneficiary arising out of that policy, or if the insurer enters a general appearance in any such action:

(i) Wet marine and transportation insurance;

(ii) Insurance on subjects located, resident or to be performed wholly outside this state, or on vehicles or aircraft owned and principally garaged outside this state;

(iii) Insurance on property or operations of railroads engaged in interstate commerce; or

(iv) Insurance on aircraft or cargo of that aircraft, or against liability, other than employer's liability, arising out of the ownership, maintenance or use of that aircraft.

26-12-205. Defense of action by unauthorized insurer.

(a) Before an unauthorized insurer files or causes to be filed any pleading in any action or proceeding instituted against it under W.S. 26-12-202 and 26-12-203, that insurer shall:

(i) Procure a certificate of authority to transact insurance in this state; or

(ii) Deposit with the clerk of the court in which the action or proceeding is pending cash or securities, or file with the clerk a bond with good and sufficient sureties, to be approved by the court, in an amount the court fixes sufficient to secure the payment of any final judgment which may be rendered in the action, except that the court may make an order dispensing with the deposit or bond if the insurer shows to the court's satisfaction that it:

(A) Maintains in a state of the United States funds or securities sufficient and available to satisfy any final judgment which may be entered in the action or proceeding; and

(B) Will pay any final judgment entered therein without requiring suit to be brought on the judgment in the state where the funds or securities are located.

(b) The court in any action or proceeding in which service is made in the manner provided in W.S. 26-12-203 may order a postponement as necessary to afford the defendant reasonable opportunity to comply with the provisions of subsection (a) of this section and to defend the action.

(c) Nothing in subsection (a) of this section prevents an unauthorized insurer from filing a motion to quash or to set aside the service of any process made in the manner provided in W.S. 26-12-203 on the ground either:

(i) That the unauthorized insurer did not engage in any of the acts enumerated in W.S. 26-12-202; or

(ii) That the person on whom service was made pursuant to W.S. 26-12-203 was not engaged in any of the acts enumerated in W.S. 26-12-202.

26-12-206. Attorney fees in actions against unauthorized insurer.

In any action against an unauthorized insurer, if the insurer fails for thirty (30) 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 the refusal is without reasonable cause, the court shall allow to the plaintiff a reasonable attorney fee and include that fee in any judgment that may be rendered in the action. The fee shall not be less than one hundred dollars ($100.00). Failure of an insurer to defend any such action is prima facie evidence that its failure to make payment was without reasonable cause.

ARTICLE 3 - UNAUTHORIZED INSURERS FALSE ADVERTISING PROCESS ACT

26-12-301. Short title.

This article constitutes and may be cited as the "Unauthorized Insurers False Advertising Process Act".

26-12-302. False advertising prohibited; notification by commissioner of misrepresentation.

No unauthorized insurer, in any manner, shall misrepresent to any person in this state as to its financial condition or the terms of any contract issued or to be issued by it or the advantages thereof, or the dividends or share of the surplus to be received thereon. If the commissioner believes that any

unauthorized insurer is misrepresenting any of the items specified in this section, he shall notify the insurer and the insurance supervisory official of the insurer's domiciliary state or province by registered or certified mail.

26-12-303. Enforcement by commissioner; penalty for violation.

(a) If within thirty (30) days following the giving of the notice specified in W.S. 26-12-302 the insurer has not ceased dissemination of any false advertising, and if the commissioner believes that the insurer is soliciting, issuing or delivering contracts of insurance to residents of this state or collecting premiums on those contracts or performing any other transaction in connection with that insurance, and that a proceeding by him in respect to those matters would be in the public interest, he shall take action against the insurer under W.S. 26-13-117.

(b) If pursuant to the proceeding the commissioner finds that the dissemination of false advertising is continuing, he shall order the insurer to desist therefrom and shall mail a copy of the order by certified or registered mail to the insurer at its principal place of business last of record with the commissioner and to the insurance supervisory official of the insurer's domiciliary state or province. Each violation after mailing of the desist order subjects the insurer to a penalty of two thousand dollars ($2,000.00), to be recovered by a civil action the commissioner brings against the insurer. Service of process upon the insurer in the action may be made upon the commissioner pursuant to W.S. 26-12-202 and 26-12-203 or in any other lawful manner.

CHAPTER 13 - TRADE PRACTICES AND FRAUDS

ARTICLE 1 - UNFAIR TRADE PRACTICES ACT

26-13-101. Short title.

This article constitutes and may be cited as the "Unfair Trade Practices Act".

26-13-102. Unfair methods and deceptive acts prohibited.

No person shall engage in this state in any trade practice which is defined in this article as or is determined pursuant to this article to be an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.

26-13-103. Misrepresentations and false advertising prohibited.

(a) No person shall:

(i) Make, issue, circulate, or cause to be made, issued or circulated, any estimate, circular or statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon;

(ii) Make any false or misleading statement as to the dividends or share of surplus previously paid on similar policies;

(iii) Make any misleading representation or any misrepresentation as to the financial condition of any insurer or as to the legal reserve system upon which any life insurer operates; or

(iv) Use any name or title of any policy or class of policies misrepresenting the true nature thereof.

26-13-104. Home office false advertising prohibited.

No person shall make in any manner in any advertising or other communication medium any advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading.

26-13-105. "Twisting" prohibited.

No person shall make or issue, nor cause to be made or issued, any written or oral statement misrepresenting or making incomplete comparisons as to the terms, conditions or benefits contained in any policy for the purpose of inducing or attempting to induce the policyholder to lapse, forfeit, surrender, retain, exchange or convert any insurance policy.

26-13-106. False or misleading financial statements prohibited.

(a) No person shall:

(i) File with any supervisory or other public official or in any manner place or cause to be placed before any other person, any false statement of financial condition of an insurer with intent to deceive;

(ii) Make any false entry in any book, report or statement of any insurer with intent to deceive:

(A) Any agent or examiner lawfully appointed to examine into its condition or into any of its affairs; or

(B) Any public official to whom the insurer is required by law to report, or who has authority by law to examine into its condition or into any of its affairs.

(iii) With intent to deceive, willfully omit a true entry of any material fact pertaining to the insurer's business in any book, report or statement of the insurer; or

(iv) Advertise the capital or assets of an insurer without in the same advertisement setting forth the amount of the insurer's liabilities in equal prominence to the statement of capital and assets.

26-13-107. Defamation prohibited.

No person shall make or aid, abet or encourage the making in any manner in any communication medium of any oral or written statement which is false or maliciously critical of or derogatory to an insurer's financial condition, or of an organization proposing to become an insurer, and which is made to injure any person engaged or proposing to engage in the insurance business.

26-13-108. Boycott, coercion and intimidation prohibited; exception.

No person shall enter into any agreement to commit, or by any concerted action commit, any act of boycott, coercion or intimidation resulting in unreasonable restraint of or any monopoly in any business of insurance, except that an insurer owned or controlled by an association or organization may refuse to renew a casualty or liability policy because of nonpayment of dues to the association or organization if payment of dues is a prerequisite to obtaining or continuing the insurance.

26-13-109. Unfair discrimination prohibited.

(a) No person shall make or permit any unfair discrimination between current or prospective insureds or insured risks:

(i) Repealed by Laws 2023, ch. 32, § 2.

(ii) Of the same class, having similar insuring or risk characteristics and of essentially the same hazard in:

(A) The amount of premium, policy fees or rates charged for any policy or contract of insurance;

(B) The dividends or benefits payable thereunder;

(C) Any of the terms or conditions of the contract; or

(D) Any other manner.

(b) Repealed by Laws 2023, ch. 32, § 2.

26-13-110. Rebates.

(a) Except as otherwise provided by law, no person shall:

(i) Authorize, offer to make or make any contract of insurance or agreement as to that contract other than as expressed in the contract issued thereon;

(ii) Pay, allow or give or offer to pay, allow, give, receive or accept in any manner as inducement to the purchase of insurance or renewal of insurance:

(A) Any rebate, discount, credit or reduction of premiums payable on the contract;

(B) Any special favor or advantage in the dividends or other benefits thereon;

(C) Any paid employment or contract for services of any kind; or

(D) Any valuable consideration or inducement not specified in the contract.

(iii) In any manner give, sell or purchase or offer or agree to give, sell, purchase or allow as inducement to the insurance or in connection therewith, and whether or not to be specified in the policy or contract, any agreement of any form or nature promising:

(A) Returns and profits;

(B) Any stocks, bonds or other securities, or interest present or contingent therein or as measured thereby, of any insurer or other corporation, association or partnership; or

(C) Any dividends or profits accrued or to accrue thereon.

(iv) Offer or provide insurance as an inducement to the purchase of another policy or use the words "free", "no cost" or similar wording in an advertisement;

(v) Unfairly discriminate against a customer when offering or declining to offer any of the items authorized by subsection (c) of this section.

(b) Nothing in W.S. 26-13-109 or subsection (a) of this section shall prohibit any of the following practices:

(i) Paying bonuses to customers or abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided that any bonuses or abatement of premiums are fair and equitable to customers and are in the insurer and its customers' best interests;

(ii) Making allowances to customers who have continuously made premium payments directly to the office of an insurer in an amount which fairly represents the saving in collection expense;

(iii) Readjustment of the premium rate for a group insurance policy based on the loss or expense experienced by the insurer, which may be made retroactive only for that policy year;

(iv) Reduction of premium rates for policies of large amount, but not exceeding savings in issuance and administration expenses reasonably attributable to those policies as compared with policies of a similar plan issued in smaller amounts;

(v) Reduction in premium rates for life or disability insurance policies on annuity contracts on salary savings, payroll deduction, preauthorized check, bank draft or similar plans in amounts reasonably commensurate with the savings made by the use of those plans;

(vi) Allowing or returning to an insurer's participating customers, members or subscribers dividends, savings or unabsorbed premium deposits;

(vii) The payment of commissions or other compensation to licensed producers;

(viii) The selling or offering for sale, contemporaneously with life insurance, of mutual fund shares or face amount certificates of regulated investment companies under offerings with the securities and exchange commission if the shares or face amount certificates and the life insurance may be purchased independently, at the same price as and upon the same terms and conditions as if purchased contemporaneously;

(ix) The offer or provision by insurers, producers or their affiliates of a product or service at no cost or a reduced cost when the product or service is not specified in the policy of insurance and the product or service:

(A) Relates to the insurance coverage;

(B) Is primarily designed to satisfy one (1) or more of the following:

(I) Provide loss mitigation or loss control;

(II) Reduce claim costs or claim settlement costs;

(III) Provide education about liability risks or risk of loss to persons or property;

(IV) Monitor or assess risk, identify sources of risk or develop strategies for eliminating or reducing risk;

(V) Enhance health;

(VI) Enhance financial wellness through items such as education or financial planning services;

(VII) Provide post-loss services;

(VIII) Incentivize behavioral changes to improve the health or reduce the risk of death or disability of a customer; or

(IX) Assist in the administration of retirement benefit insurance coverage.

(C) The cost to the insurer or producer offering the product or service to any given customer is reasonable in comparison to that customer's premiums or insurance coverage for the policy class;

(D) The insurer or producer ensures that the customer is provided with contact information to assist the customer with questions regarding the product or service;

(E) The availability of offered products or services shall be based on documented objective criteria, which shall by maintained by the insurer or producer and produced upon request by the department. If the insurer or producer does not have sufficient evidence, but has a good-faith belief that the offered products or services meet the criteria, the insurer or producer may provide the products or services as part of a pilot or testing program for no more than one (1) year. The department shall be notified of any pilot or testing program prior to launching. The program may proceed unless the department objects within thirty (30) days of notice.

(c) Unless prohibited by paragraphs (a)(ii) and (iii) of this section, an insurer or producer may:

(i) Offer or give non-cash gifts, items or services to customers in connection with the marketing, sale, purchase or retention of contracts of insurance, provided that the cost of the gifts, items or services are not included in any amounts charged to another person or entity. The customer shall not be required to purchase, continue to purchase or renew a policy in exchange for the gift, item or service. The total value of the gift, item or service per customer per calendar year shall not exceed:

(A) One hundred dollars ($100.00) or five percent (5%), but not to exceed one thousand dollars ($1,000.00), of the written premium for current customers; or

(B) One hundred dollars ($100.00) or five percent (5%), but not to exceed one thousand dollars ($1,000.00), of the quoted premium for prospective customers.

(ii) Conduct raffles or drawings for prizes to the extent permitted by state law at no cost to entrants. The drawing or raffle shall not obligate participants to purchase insurance and shall be open to the public. The customer shall not be required to purchase or renew a policy in exchange for entrance into the raffle or drawing. The total value of each raffle or drawing shall not exceed one hundred dollars ($100.00).

(d) Any person who provides any gift, item, service or prize under subsection (c) of this section shall retain records which shall be considered records of transactions under W.S. 26-9-228 and which shall be provided for inspection upon request of the commissioner. These records shall include but are not limited to receipts of purchase, dates of transaction and names of customers.

(e) The commissioner may adopt rules and regulations when implementing the permitted practices set forth in this section to ensure consumer protection.

(f) As used in this section:

(i) "Insurance" means as defined by W.S. 26-1-102(a)(xv) and also includes suretyship;

(ii) "Policy" means as defined by W.S. 26-1-102(a)(xxi) and also includes bond;

(iii) "Customer" means a policyholder, potential policyholder, certificate holder, potential certificate holder, insured, potential insured or applicant.

26-13-111. Repealed by Laws 2023, ch. 32, § 2.

26-13-112. Repealed by Laws 2023, ch. 32, § 2.

26-13-113. Deductible amount of collision coverage; subrogation; right to deductible.

(a) If an insurer pays a loss claim to its insured and the insurer decides to subrogate to the insured's loss claim, the deductible amount shall be included in the subrogated loss claim and the insurance carrier shall pay the deductible amount to its insured, without any deduction for expenses of collection, out of any recovery on the subrogated claim, before any part of the recovery is applied to any other use. If the amount of the deductible exceeds the recovery, the insurer shall pay only the amount of the recovery to the insured.

(b) If in any arbitration of the subrogated claim two (2) or more insurers agree to offset the claims of their insureds, the right of any insured to the return of his full deductible amount shall not be abridged.

26-13-114. Securities operations and advisory board contracts as insurance inducement prohibited.

No insurer or other person shall offer, issue or deliver or permit its agents, officers or employees to offer, issue or deliver, in this or any other state, agency company stock or other capital stock, benefit certificates, shares in any common-law corporation or any advisory board contract promising returns and profits as an inducement to insurance.

26-13-115. Desist orders by commissioner; appeal; violation of order.

(a) If the commissioner finds that any person in this state, after a hearing in which the person is notified of the hearing and the charges against him, has engaged or is engaging in any act or practice defined in or prohibited under this chapter, the commissioner shall order the person to desist from the acts or practices.

(b) The desist order is final upon expiration of the time allowed for appeals from the commissioner's orders, if no appeal is taken, or, if there is an appeal, upon final decision of the court if the court affirms the commissioner's order or dismisses the appeal. An intervenor in the hearing may appeal as provided in W.S. 26-2-129.

(c) If there is an appeal, to the extent that the commissioner's order is affirmed, the court shall issue its own order commanding obedience to the terms of the commissioner's order.

(d) No order of the commissioner pursuant to this section or order of the court to enforce it in any way relieves or absolves any person affected by the order from any other liability, penalty or forfeiture under law.

(e) Violation of any desist order is punishable as a violation of this code.

(f) This section does not affect or prevent the imposition of any penalty provided by this code or by other law for violation of any other provision of this chapter, whether or not any hearing is called or held or any desist order issued.

26-13-116. Procedures for undefined deceptive practices.

(a) If the commissioner believes that any person in conducting an insurance business in this state is engaging in any method of competition or in any act or practice, not defined in this chapter, which is unfair or deceptive and that a proceeding by him in respect thereto would be in the public interest, after a hearing in which the person charged receives a notice of the hearing and of the charges against him, the commissioner shall make a written report of his findings of fact relative to the charges and serve a copy thereof upon the person and any intervenor at the hearing.

(b) If the commissioner's report charges a violation of this chapter and if the method of competition, act or practice is not discontinued, the commissioner, through the attorney general, at any time after service of the report, may cause an action to be instituted to enjoin and restrain the person from engaging in the method, act or practice. In the action the court may grant a restraining order or injunction upon any just terms, but the people of this state are not required to give security before the issuance of the order or injunction. If a stenographic record of the proceedings in the hearing before the commissioner is made, a certified transcript thereof including all evidence taken and the report and findings shall be received in evidence in the action.

(c) If the commissioner's report made under subsection (a) of this section or order on hearing made under W.S. 26-2-128 does not charge a violation of this chapter, then any intervenor in the proceedings may appeal within the time and in the manner provided in W.S. 26-2-129(b).

26-13-117. Service of process upon unauthorized insurers.

(a) Service of all process, statements of charges and notices under this chapter upon unauthorized insurers shall be made in accordance with W.S. 26-3-122.

(b) The commissioner shall forward all process, statements of charges and notices to the insurer in the manner provided in W.S. 26-3-122.

(c) No default shall be taken against any unauthorized insurer until expiration of thirty (30) days after the date of forwarding by the commissioner under subsection (b) of this section, or date of service of process if under W.S. 26-12-203(b).

(d) W.S. 26-12-203(d) applies to all process, statements of charges and notices under this section.

26-13-118. Favored agent or insurer.

(a) No person shall require as a condition to loaning money upon the security of any real or personal property, or to the selling of that property under contract, that the owner of the property to whom the money is to be loaned or the vendee of the property being sold, shall place, continue or renew any policy of insurance covering the property, or covering any liability related to the property or the use thereof, through a particular insurance agent or broker or in a particular insurer. This does not prevent the lender or vendor, upon a reasonable basis, from approving or disapproving of the insurer and representative selected to underwrite the insurance, but the basis for approval or disapproval shall relate only to:

(i) The adequacy and terms of the coverage with respect to the interest of the vendor or lender to be insured thereunder;

(ii) The financial standards to be met by the insurer; and

(iii) The ability of the insurer or representative to service the policy.

26-13-119. Interlocking ownership and management.

(a) Any insurer may retain, invest in or acquire the whole or any part of the capital stock of any other insurer, or have a common management with any other insurer, unless the retention, investment, acquisition or common management is inconsistent with any other provision of this code, or unless by reason thereof the insurers' business with the public is conducted in a manner which substantially lessens competition generally in the insurance business or tends to create any monopoly therein.

(b) Any person otherwise qualified may be a director of two (2) or more insurers which are competitors, unless the effect thereof is to lessen substantially competition between insurers or tends materially to create a monopoly.

26-13-120. Political contributions prohibited; penalty.

(a) No insurer shall in any manner pay or use, or offer, consent or agree to pay or use, any money or property:

(i) For or in aid of any:

(A) Political party, committee or organization;

(B) Corporation or other body organized or maintained for political purposes;

(C) Candidate for political office;

(D) Nomination for office; or

(E) Other political purpose; or

(ii) For the reimbursement or indemnification of any person for money or property so used.

(b) Any officer, director, stockholder, attorney or agent of any insurer which violates this section, who participates in, aids, abets, advises or consents to any such violation, and any person who solicits or knowingly receives any money or property in violation of this section, is guilty of a misdemeanor and shall be punished by imprisonment for not more than one (1) year and a fine of not more than one thousand dollars ($1,000.00). Any officer or director abetting in any contribution made in violation of this section is liable to the insurer for the amount so contributed.

(c) This section does not prohibit an insurer from otherwise lawful expenditures for presentation of information to legislators relative to proposed legislation affecting the insurer.

26-13-121. Illegal dealing in premiums; excess charges for insurance.

(a) No person shall willfully collect any sum as premium or charge for insurance:

(i) If the insurance is not then provided or is not in due course to be provided, subject to the insurer's acceptance of the risk, by an insurance policy issued by the insurer as authorized by this code;

(ii) In excess of the premium or charge applicable to the insurance, and as specified in the policy, in accordance with the applicable classifications and rates as filed with and approved by the commissioner; or

(iii) In cases where classifications, premiums or rates are not required by this code to be filed and approved, in excess of those specified in the policy and as fixed by the insurer.

(b) Subsection (a) of this section does not prohibit the charging and collection by surplus lines brokers licensed under chapter 11 of this code of the amount of applicable state and federal taxes, examination fee and nominal service charge to cover communication expenses, in addition to the premium required by the insurer. Nor does it prohibit the charging and collection by a life insurer of amounts actually to be expended for medical examination of an applicant for life insurance or for reinstatement of a life insurance policy.

(c) Each violation of this section is punishable under W.S. 26-1-107.

26-13-122. Fictitious groups prohibited.

(a) No authorized or unauthorized insurer shall make available, through any rating plan or form, property, casualty or surety insurance to any firm, corporation or association of individuals at any preferred rate or premium based upon any fictitious grouping of the firm, corporation or association.

(b) No form or plan of insurance covering any group or combination of persons or risks shall be written or delivered within or outside this state to cover persons or risks in this state at any preferred rate or on any form other than as offered to persons not in the group or combination and to the public generally, unless the form, plan of insurance and the rates or premiums to be charged therefor have been submitted to and approved by the commissioner as being not unfairly discriminatory, and as not otherwise being in conflict with subsection (a) of this section or with chapter 14 of this code to the extent that chapter 14 is applicable thereto.

(c) This section does not apply to life insurance, disability insurance or annuity contracts.

26-13-123. Repealed by Laws 1995, ch. 175, § 2.

26-13-124. Unfair claims settlement practices.

(a) A person is considered to be engaging in an unfair method of competition and unfair and deceptive act or practice in the business of insurance if that person commits or performs with such frequency as to indicate a general business practice any of the following unfair claims settlement practices:

(i) Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

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

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

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

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

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

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

(viii) Attempting to settle a claim for less than the amount to which a reasonable person would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application;

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

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

(xi) 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;

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

(xiii) Failing to promptly settle claims, where liability has become reasonably clear, under one (1) portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage;

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

(xv) Denying or failing to timely pay disability insurance claims for medically necessary services, procedures or supplies as required by W.S. 26-40-201;

(xvi) Failing to comply with the external review procedures required by W.S. 26-40-201; or

(xvii) Failing to pay a claim after an external review organization has declared such claim to be a benefit covered under the terms of the insurance policy.

26-13-125. Certificates of insurance.

(a) No person shall prepare, issue or knowingly request the issuance of a certificate of insurance unless the form has been filed and approved in accordance with W.S. 26-15-110. No person shall alter or modify a certificate of insurance form unless the alteration or modification has been filed and approved in accordance with chapter 15 of this code.

(b) The commissioner shall disapprove the use of, or prohibit the use of, a certificate of insurance form filed under this section if the certificate of insurance form:

(i) Is unfair, misleading or deceptive;

(ii) Violates public policy; or

(iii) Fails to comply with this section or any other law of this state.

(c) The forms used for a certificate of insurance for surplus lines policies issued pursuant to the nonadmitted insurance law, W.S. 26-11-101 et seq., are not subject to the approval requirements of W.S. 26-15-110. Certificates issued for surplus lines insurance policies shall use either:

(i) A form approved for the policy by the insurer's home state; or

(ii) A standard form used by the issuing insurer if there is no relevant form approved by the home state.

(d) Each certificate of insurance shall contain the following or similar statement: "This certificate of insurance is issued as a matter of information only and confers no rights upon the certificate holder. Subject to W.S. 26-13-125(e), this certificate does not alter, amend or extend the coverage, terms, exclusions and conditions afforded by the policies referenced herein."

(e) No person shall demand or request the issuance of a certificate of insurance or other document, record or correspondence that the person knows contains any false or

misleading information or that purports to affirmatively or negatively alter, amend or extend the coverage provided by the policy of insurance to which the certificate makes reference.

(f) The provisions of this section shall apply to all certificate holders, third party certificate administrators, policy holders, insurers, insurance producers and certificate of insurance forms issued as evidence of property or casualty insurance coverages on property, operations or risks located in this state, regardless of where the certificate holder, policy holder, insurer or insurance producer is located.

(g) A certificate of insurance is not a policy of insurance and does not affirmatively or negatively alter, amend or extend the coverage afforded by the policy to which the certificate of insurance makes reference. A certificate of insurance shall not confer to a certificate holder any new or additional rights beyond what the referenced policy or insurance provides. Any coverage or policy limits listed on the certificate of insurance shall accurately reflect policy limits.

(h) No certificate of insurance shall contain references to contracts other than the underlying contracts of insurance, including construction or service contracts. Notwithstanding any requirement, term or condition of any contract or other document with respect to which a certificate of insurance may be issued or may pertain, the insurance afforded by the referenced policy of insurance is subject to all the terms, exclusions and conditions of the policy itself.

(j) A person is entitled to receive notice of cancellation, nonrenewal or any material change or any similar notice concerning a policy of insurance only if the person has notice rights under the terms of the policy or any endorsement to the policy. The terms and conditions of the notice, including the required timing of the notice, are governed by the policy of insurance or endorsement and may not be altered by a certificate of insurance.

(k) Any certificate of insurance or any other document, record or correspondence prepared, issued or requested in violation of this section shall be null and void and of no force and effect.

(m) As used in this section:

(i) "Certificate" or "certificate of insurance" means any document or instrument, no matter how titled or described, which is prepared or issued as evidence of property or casualty insurance coverage. "Certificate" or "certificate of insurance" shall not include a policy of insurance, a certificate issued to a policyholder under a group master policy, an insurance binder, a policy endorsement, and automobile insurance identification card, or a certificate prepared or issued pursuant to any federal law, rule or regulation or any other law, rule or regulation of this state, in which the specific content and form of the certificate is enumerated therein;

(ii) "Certificate holder" means any person, other than a policyholder, who requests, obtains or possesses a certificate of insurance;

(iii) "Group master policy" means an insurance policy that provides coverage to eligible persons on a group basis through a group insurance program;

(iv) "Policyholder" means a person who has contracted with a property or casualty insurer for insurance coverage.

ARTICLE 2 - FALSE APPLICATIONS, CLAIMS AND PROOF OF LOSS

26-13-201. False applications, claims and proofs of loss prohibited.

(a) No person shall knowingly or willfully:

(i) Make any false or fraudulent statement or representation in or with reference to any application for insurance or for the purpose of obtaining any money or benefit;

(ii) Present or cause to be presented a false or fraudulent claim or any proof in support of a claim for the payment of the loss upon a contract of insurance;

(iii) Prepare, make or subscribe a false or fraudulent certificate, or other document with intent that the certificate or other document may be presented or used in support of the claim.

26-13-202. Penalties.

Any person who violates this article is subject to the penalty provided in W.S. 26-1-107, or as provided by any other applicable law which provides a greater penalty.

ARTICLE 3 - DISCRETIONARY CLAUSE PROHIBITION ACT

26-13-301. Short title.

This act shall be known and may be cited as the "Discretionary Clause Prohibition Act."

26-13-302. Purpose and intent.

The purpose of this act is to assure that health insurance benefits not subject to the federal Employee Retirement Income Security Act are contractually guaranteed, and to avoid the conflict of interest that occurs when the carrier responsible for providing benefits has discretionary authority to decide what benefits are due. This act is also intended to assure that health insurance benefits contracts subject to the federal Employee Retirement Income Security Act which contain a discretionary clause provide appropriate disclosure of the clause and additional provisions to assure a fair determination of contract benefits. Nothing in this act shall be construed as imposing any requirement or duty on any person other than a health carrier.

26-13-303. Definitions.

(a) As used in this act:

(i) "Commissioner" means as defined in W.S. 26-1-102(a)(viii);

(ii) "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease;

(iii) "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services;

(iv) "Person" means as defined in W.S. 8-1-102(a)(vi);

(v) "This act" means W.S. 26-13-301 through 26-13-305.

26-13-304. Discretionary clause prohibited.

(a) No policy, contract, certificate or agreement offered or issued in this state by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services may contain a provision purporting to reserve discretion to the health carrier to interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with the laws of this state. This subsection shall not apply to a policy, contract, certificate or agreement subject to and meeting the requirements of subsections (b) and (c) of this section.

(b) Any group policy, contract, certificate or agreement subject to the federal Employee Retirement Income Security Act and offered or issued in this state by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services and which contains a provision purporting to reserve discretion to the health carrier to interpret the terms of the contract or to provide standards of interpretation or review shall contain the following language highlighted in bold in not less than twelve (12) point type:

This benefit plan contains a discretionary clause. Determinations made by (insurer name) pursuant to the discretionary clause do not prohibit or prevent a claimant from seeking judicial review in court of (insurer name's) decisions. By including this discretionary clause (insurer's name) agrees to allow a court to review its determinations anew when a claimant seeks judicial review of (insurer name's) determinations of eligibility of benefits, the payment of benefits or interpretations of the terms and conditions applicable to the benefit plan.

(c) Any group policy, contract, certificate or agreement containing a discretionary clause as authorized in subsection (b) of this section shall contain a provision entitling any person denied benefits in whole or in part to have the determination reviewed de novo in any court with jurisdiction.

26-13-305. Penalties.

Any person who violates this act is subject to the penalty provided in W.S. 26-1-107, or as provided by any other applicable law which provides a greater penalty.

CHAPTER 14 - RATES AND RATING ORGANIZATIONS

26-14-101. Purpose of chapter; liberal interpretation.

The purpose of this chapter is to protect the public and policyholders against the effects of excessive, inadequate or unfairly discriminatory rates by promoting price competition among insurers. The provisions in this chapter are intended to prohibit unlawful price fixing agreements by or among insurers and to authorize essential cooperative activities among insurers in the rate making process and to regulate these activities to prohibit practices that tend to substantially lessen competition or create monopolies. This chapter shall be liberally interpreted to carry into effect the provisions of this section.

26-14-102. Scope and applicability of chapter; liberal interpretation.

(a) This chapter applies to all kinds of insurance written on risks in this state by any insurer authorized to do business, except nothing in this chapter applies to:

(i) Life insurance;

(ii) Disability insurance;

(iii) Reinsurance;

(iv) Insurance against loss of or damage to aircraft, their hulls, accessories and equipment, or against liability arising out of the ownership, maintenance or use of aircraft;

(v) 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;

(vi) Title insurance;

(vii) Annuities;

(viii) Worker's compensation insurance as provided under title 27, chapter 14 of the Wyoming statutes.

(b) No insurer shall be required to file any rates with the commissioner other than those for insurance not subject to this act or defined as noncompetitive in this act, after the passage of this act.

(c) This chapter shall be liberally interpreted to carry out the purpose specified in W.S. 26-14-101.

26-14-103. Definitions.

(a) As used in this chapter:

(i) "Advisory organization" means any person or organization which assists insurers as authorized by W.S. 26-14-110. It does not include joint underwriting organizations, actuarial or legal consultants, a single insurer, any employees of an insurer or insurers under common control or management of their employees or managers;

(ii) "Competitive market" means any market except those which are noncompetitive pursuant to this chapter;

(iii) "Excessive" means a rate that is likely to produce a long-term profit that is unreasonably high for the insurance provided. In a competitive market rates shall not be considered excessive;

(iv) "Inadequate" means a rate which is unreasonably low for the insurance provided and the continued use of which endangers the solvency of the insurer using it or will have the effect of substantially lessening competition or creating a monopoly in any market;

(v) "Joint underwriting" means an arrangement established to provide insurance coverage for a risk, pursuant to which two (2) or more insurers contract with the insured for a price and policy terms agreed upon between or among the insurers;

(vi) "Market" means the statewide interaction between buyers and sellers in the procurement of a line of insurance coverage pursuant to the provisions of this chapter;

(vii) "Noncompetitive market" means:

(A) Residual markets;

(B) Pools;

(C) Credit property insurance, including vendors' single interest physical damage insurance where the buyer pays a separate charge for insurance; or

(D) Any market in which:

(I) There are less than five (5) insurers actually issuing a particular line of insurance as determined by the commissioner;

(II) Three (3) insurers transact more than ninety percent (90%) of the business;

(III) Two (2) insurers transact more than eighty percent (80%) of the business; or

(IV) There is reasonable evidence, as determined by the commissioner, of collusion among insurers in setting prices.

(viii) "Pool" means an arrangement pursuant to which two (2) or more insurers participate in the sharing of risks on a predetermined basis. A pool may operate as an association, syndicate or in any other generally recognized manner;

(ix) "Residual market mechanism" means an arrangement, either voluntary or mandated by law, involving participation by insurers in the equitable apportionment of risks among insurers for insurance which may be afforded applicants who are unable to obtain insurance through ordinary methods;

(x) "Supplementary rate information" means any manual or plan of rates, classification, rating schedule, minimum premium, policy fee, rating rule and any other similar information needed to determine an applicable rate in effect or to be in effect;

(xi) "Supporting information" means the experience and judgment of the filer and the experience or data of other insurers or organizations relied upon by the filer, the interpretation of any statistical data relied upon by the filer,

a description of methods used in making the rates and other similar information relied upon by the filer;

(xii) "Unfairly discriminatory" refers to rates that cannot be actuarially justified. It does not refer to rates that produce differences in premiums for policyholders with like loss exposures but different expenses, or like expenses but different loss exposures, so long as the rate reflects such differences with reasonable accuracy. A rate is not unfairly discriminatory if it averages broadly among persons insured under a group, franchise or blanket policy or a mass marketing plan. No rate in a competitive market shall be considered unfairly discriminatory unless it violates the provisions of W.S. 26-14-105(b) in that they classify in whole or in part on the basis of race, color, creed or national origin.

26-14-104. Competitive market presumed to exist.

A competitive market is presumed to exist except as otherwise provided by this chapter.

26-14-105. Rating standards; methods.

(a) Rates shall not be excessive, inadequate or unfairly discriminatory.

(b) Risks may be classified in any way except that no risk may be classified in whole or in part on the basis of race, color, creed or national origin. In determining whether rates in a noncompetitive market are excessive, inadequate or unfairly discriminatory, consideration may be given to the following elements:

(i) Basic Rate Factors.-Consideration may be given to past and prospective loss and expense experience within and outside of this state, to catastrophe hazards and contingencies, to events or trends within and outside of this state, to dividends or savings to policyholders, members or subscribers and to all other factors and judgments deemed relevant by the insurer;

(ii) Classification.-Rates may be modified for individual risks in accordance with rating plans or schedules which establish standards for measuring probable variations in hazards or expenses, or both;

(iii) Expenses.-The expense provisions shall reflect the operating methods of the insurer and, so far as credible, its own actual and anticipated expense experience; and

(iv) Contingencies and Profits.-The rates may contain a provision for contingencies and a provision for a reasonable underwriting profit, and shall reflect investment income directly attributable to unearned premium and loss reserves.

(c) Repealed by Laws 2021, ch. 138, § 1.

26-14-106. Rate regulation.

(a) Rates in a noncompetitive market, when regulated, shall be regulated in accordance with W.S. 26-14-105 through 26-14-108 applicable to noncompetitive markets.

(b) The commissioner may regulate rates in an unregulated market if he determines that:

(i) The unregulated market is a noncompetitive market; and

(ii) Regulation will likely reduce rates for consumers in a total amount greater than the cost of regulation without substantially curtailing the availability of insurance in that market.

(c) The commissioner may declare a noncompetitive market competitive if he determines the noncompetitive market no longer meets the conditions of a noncompetitive market as defined in W.S. 26-14-103(a)(vii).

(d) To carry out the purpose of subsections (b) and (c) of this section, the commissioner, upon his own motion, may conduct a rate or other investigation. The commissioner shall conduct a rate or other investigation upon request of:

(i) Not less than ten percent (10%) of the insureds in any market;

(ii) Any organization representing not less than ten percent (10%) of the insureds in any market; or

(iii) Insurers selling at least thirty percent (30%) of the insurance in any market.

(e) The commissioner shall not be compelled to conduct an investigation of any line of insurance pursuant to subsection (d) of this section more than once in any three (3) year period for any line of insurance but may do so.

(f) As a part of any investigation under subsection (d) of this section the commissioner:

(i) May require any insurer to submit actuarial and expense data relating to any line of insurance;

(ii) May contract the services of an actuarial consultant and assess the cost thereof against the parties requesting the investigation or against the insurers affected if the investigation is conducted upon the commissioner's motion;

(iii) Shall conduct a hearing upon not less than twenty (20) days written notice to affected parties, provided this requirement may be waived upon written agreement of the affected parties;

(iv) Depending upon the availability of data and the existence of sufficient experience to allow for an actuarially sound determination, may base any regulation of rates for any line of insurance under this section on experience or loss data for that line of insurance in:

(A) Wyoming alone;

(B) Wyoming and selected other states with reasonably similar characteristics; or

(C) The United States as a whole excluding states whose experience is atypical.

(g) For rates regulated pursuant to subsections (a) and (b) of this section, there shall be a public hearing if within any twelve (12) month period an insurer requests approval of a base premium rate which when added to any other base premium rates pending or approved within that twelve (12) month period is twenty percent (20%) or more above the rate approved for the previous rating period. For health care professional malpractice insurance, a rate increase of more than twenty-five percent (25%) in any specialty shall cause a consolidated hearing on the rate increase. The informational hearing shall be held within sixty (60) days of the request for approval unless the commissioner delays the hearing for good cause. If the hearing

is delayed the commissioner shall notify the insurer and any other person requesting notification of the reasons for the delay.

(h) The following shall apply to any market found to be noncompetitive pursuant to subsections (a) and (b) of this section and to any professional liability insurance for any health care provider licensed under title 33 of the Wyoming statutes:

(i) The rate charged any individual insured shall not exceed the base rate approved by the commissioner for the insured's risk class by more than one hundred percent (100%), unless the commissioner has established for the applicable risk class a percentage limit of less than one hundred percent (100%);

(ii) The rate charged an insured for extended reporting coverage following expiration, termination or nonrenewal of the insured's claims-made policy shall be subject to the following:

(A) The rate shall be calculated according to a formula set forth in the insured's policy, which formula shall be subject to approval by the commissioner;

(B) The formula shall be expressed as a percentage of the base rate for the insured's risk class or that insured's underwritten rate;

(C) The percentage may be varied on a uniform basis for each risk class by the length of time during which the events covered by the extended reporting coverage may have arisen; and

(D) If an individual elects to purchase the extended reporting coverage before the renewal date of his policy, the rates charged for the extended reporting coverage shall be computed based on the relevant rates for that insured before the renewal, not the rates that would be in effect upon renewal.

26-14-107. Filing of rates; supplementary rate information; supporting information; public inspection; consent to rates.

(a) In competitive markets, every insurer shall maintain all rates and supplementary rate information to be used in this state, in accordance with the provisions of W.S. 26-14-113(b), and such information shall be made available to the commissioner upon his request.

(b) In noncompetitive markets, every insurer shall file with the commissioner all rates, supplementary rate information and supporting information for noncompetitive markets at least thirty (30) days before the proposed effective date. The commissioner may give written notice, within thirty (30) days of the receipt of the filing, that he needs additional time, not to exceed thirty (30) days from the date of the notice, to consider the filing. Upon written application of the insurer, the commissioner may authorize rates to be effective before the expiration of the waiting period or an extension thereof. A filing shall be deemed to meet the requirements of this chapter and to become effective unless disapproved pursuant to W.S. 26-14-108 by the commissioner before the expiration of the waiting period or an extension thereof. Residual market mechanisms or advisory organizations may file residual market rates. The filing shall be deemed in compliance with the filing provisions of this section unless the commissioner informs the insurer within ten (10) days after receipt of the filing as to what supplementary rate information or supporting information is required to complete the filing.

(c) All information provided to the insurance commissioner under this chapter shall be open to public inspection. Copies may be obtained from the commissioner upon request and upon payment of a reasonable fee.

(d) Notwithstanding any other provisions of this section, upon written application of the insured, stating the reason therefor filed with the commissioner, a rate in excess of that otherwise applicable may be used on any specific risk.

26-14-108. Disapproval of rates; bases; procedures.

(a) The commissioner shall disapprove a rate for use in a noncompetitive market if he finds pursuant to subsection (b) of this section that the rate is excessive, inadequate or unfairly discriminatory.

(b) Disapproval of rates by the commissioner shall be subject to the following procedures:

(i) Prior to the expiration of the waiting period or an extension thereof of a filing made pursuant to W.S. 26-14-107(b), the commissioner may disapprove by written order rates filed pursuant to W.S. 26-14-107(b) without hearing. The order shall specify in what respects such filing fails to meet the requirements of this chapter. Any insurer whose rates are disapproved under this section shall be given a hearing upon written request made within thirty (30) days of disapproval;

(ii) If at any time the commissioner finds that a rate applicable to insurance sold in a noncompetitive market does not comply with the standards set forth in W.S. 26-14-105, he may, after a hearing held upon not less than twenty (20) days written notice, issue an order in accordance with subsection (c) of this section, disapproving the rate. Such notice shall be sent to every insurer and rate service organization which adopted the rate and shall specify the matters to be considered at the hearing. The order shall not affect any contract or policy made or issued prior to the expiration of the period set forth in the order.

(c) If the commissioner disapproves a rate pursuant to subsection (b) of this section, he shall issue an order within thirty (30) days of the close of the hearing specifying in what respects the rate fails to meet the requirements of this chapter. The order shall state an effective date no sooner than forty-five (45) business days after the date of the order when the use of the rate shall be discontinued. The order shall not affect any policy made before the effective date of the order.

26-14-109. Advisory organizations; registration required; authorized activities; availability of services.

(a) No advisory organization shall provide any service relating to the rates of any insurer subject to this chapter, and no insurer shall utilize the services of such organization for such purposes unless the organization has registered under subsection (d) of this section.

(b) A registered advisory organization may perform any of the following activities:

(i) Develop statistical plans including territorial and class definitions;

(ii) Collect statistical data from members, subscribers or any other source;

(iii) Prepare and distribute pure premium data, adjusted for loss development and loss trending, in accordance with its statistical plans, and prepare and distribute rates including expenses and profits;

(iv) Prepare and distribute manuals of rating rules and rating schedules;

(v) Distribute information that is filed with the commissioner and open to public inspection;

(vi) Conduct research and on-site inspections in order to prepare classifications of public fire defenses;

(vii) Consult with public officials regarding public fire protection as it would affect members, subscribers and others;

(viii) Conduct research and collect statistics in order to discover, identify and classify information relating to causes or prevention of losses;

(ix) Prepare and file on behalf of an insurer policy forms and endorsements and consult with members, subscribers and others relative to their use and application;

(x) Conduct research and on-site inspections for the purpose of providing risk information relating to individual structures;

(xi) Collect, compile and distribute past and current prices of individual insurers if such information is made available to the general public;

(xii) Notwithstanding any other provision of law, advisory organizations may perform those activities allowed under W.S. 26-23-301 through 26-23-333.

(c) Repealed by Laws 1987, ch. 195, § 2.

(d) No advisory organization shall refuse to supply any authorized services for which it is registered in this state to any insurer authorized to do business in this state and offering to pay the fair and usual compensation for the services, nor shall an advisory organization require the purchase of any specific services as a condition to obtaining the services

sought, provided the furnishing of the requested services does not place an unreasonable burden on the advisory organization.

(e) An advisory organization shall submit at the time of registration:

(i) A copy of its constitution, articles of association or incorporation, bylaws and any other rules or regulations governing the conduct of its business;

(ii) A list of its members and subscribers;

(iii) The name and address of one (1) or more residents of this state upon whom notices, process affecting it or on orders of the commissioner may be served;

(iv) Any other relevant information and documents that the commissioner may require.

(f) Every organization which has registered shall promptly notify the commissioner of every material change in the facts or in the documents on which its registration was based.

26-14-110. Records and reports; exchange of information.

(a) Insurers shall file with the commissioner, and the commissioner shall review, reasonable rules and plans for recording and reporting of loss and expense experience. The commissioner may designate one (1) or more advisory organizations to assist in gathering such experience and making compilations thereof. No insurer shall be required to record or report its experience in a manner inconsistent with its own rating system.

(b) The commissioner and every insurer and an advisory organization may exchange information and experience data with insurance regulatory officials, insurers, rate service organizations and advisory organizations in this and other states and may consult with them with respect to rate making and the application of rating systems.

26-14-111. Insurers and advisory organizations; monopolies prohibited; agreements to adhere prohibited.

(a) No insurer or advisory organization shall attempt to monopolize or combine or conspire with any other person to monopolize an insurance market in this state.

(b) Except as otherwise provided in this chapter, no insurer shall agree with any other insurer, rate service organization or advisory organization to adhere to or use any rate, supplementary rate information, policy surveys, inspections or similar material.

(c) The fact that two (2) or more insurers, whether or not members or subscribers of any advisory organization, use consistently or intermittently the same rates, supplementary rate information, policy or bond forms, surveys, inspections or similar materials is not sufficient in itself to support a finding that an illegal agreement exists and may be used only for the purpose of supplementing or explaining other direct evidence of the existence of any such agreement.

(d) Two (2) or more insurers having a common ownership or operating in this state under common management or control may act in concert between or among themselves with respect to any matters pertaining to activities authorized in this chapter as if they constituted a single insurer.

26-14-112. Joint underwriting; pool and residual market activities.

(a) Insurers participating in joint underwriting, pools or residual market mechanisms may act in cooperation with each other in the making of rates, supplementary rate information, policy or bond forms, surveys, inspections and investigations, the furnishing of loss and expense statistics or other information and conducting research. Joint underwriting, pools and residual market mechanisms shall not be deemed rate advisory organizations.

(b) If, after notice and hearing, the commissioner finds that any activity or practice of an insurer participating in a joint underwriting or pooling mechanism is unfair or unreasonable, or otherwise inconsistent with the provisions or purposes of this chapter, he may issue a written order specifying in what respects such activity or practice is unfair, unreasonable, anti-competitive or otherwise inconsistent with the provisions of this chapter and require the discontinuance of such activity or practice.

(c) Every pool shall file with the commissioner a copy of its constitution, articles of incorporation, agreement or association, bylaws, rules and regulations governing activities,

the name and address of a resident of this state upon whom notices, process and orders of the commissioner may be served and any changes or modifications thereof.

(d) Any residual market mechanism, plan or agreement to implement such a mechanism, and any changes or amendments thereto, shall be submitted in writing to the commissioner for approval, together with any information as he may reasonably require. The commissioner shall approve such agreements if they foster the use of rates which meet the standards prescribed by this chapter and activities and practices not inconsistent with the provisions of this chapter.

(e) The commissioner may review the operations of all residual market mechanisms to determine compliance with the provisions of this chapter. If, after a notice and hearing, the commissioner finds that the mechanisms are violating the provisions of this chapter, he may issue a written order to the parties involved specifying in what respects the operations violate the provisions of this chapter. He may further order the discontinuance or elimination of any operation.

26-14-113. Examinations; records; costs; report in lieu of examination.

(a) The commissioner may examine any insurer, pool, advisory organization or residual market mechanism to ascertain compliance with this chapter.

(b) Every insurer, pool, advisory organization and residual market mechanism shall maintain adequate records from which the commissioner may determine compliance with the provisions of this chapter. The records shall contain the experience, data, statistics and other information collected or used and shall be available to the commissioner for examination or inspection upon reasonable notice.

(c) The reasonable cost of an examination made pursuant to this section shall be paid by the examined party upon presentation to it of a detailed account of the costs.

(d) The commissioner may accept the report of an examination made by the insurance supervisory official of another state in lieu of an examination under this section.

26-14-114. Exemptions.

The commissioner may exempt any line of insurance from any or all of the provisions of this chapter for the purpose of relieving the line of insurance from filing provisions of this chapter.

26-14-115. Dividends.

Nothing in this chapter shall be construed to prohibit or regulate the payment of dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers. A plan for the payment of dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers shall not be deemed a rating plan or system.

26-14-116. Penalties; technical violations; revocation and suspension of license; written orders; contents.

(a) The commissioner may impose after notice and hearing a penalty of not more than one thousand dollars ($1,000.00) for each violation of this chapter. The penalty may be in addition to any other penalty provided by law. In no event shall penalties imposed by this subsection exceed fifty thousand dollars ($50,000.00) in the aggregate.

(b) Technical violations arising from systems or computer errors of the same type shall be treated as a single violation. In the event of an overcharge, if the insurer makes restitution including payment of interest, no penalty shall be imposed.

(c) The commissioner may suspend or revoke the license of any insurer or advisory organization which fails to comply with an order of the commissioner within the time prescribed by the order, or any extension thereof which the commissioner may grant.

(d) The commissioner may determine when a suspension of license shall become effective and the period of the suspension, which he may modify or rescind in any reasonable manner.

(e) No penalty shall be imposed and no license shall be suspended or revoked except upon a written order of the commissioner made after notice and hearing, which shall include a finding that the party against whom the proceedings were brought violated this chapter, specify the section or sections of the statutes violated, and indicate the penalty and taxes, if any, imposed.

26-14-117. Judicial review.

Any order, ruling, finding, decision or other act of the commissioner made pursuant to this chapter shall be subject to judicial review in accordance with the Wyoming Administrative Procedure Act.

26-14-118. Notice and hearing.

(a) All notices rendered pursuant to the provisions of this chapter shall be in writing and shall state clearly the nature and purpose of the hearing. All relevant facts, statutes and rules shall be specified so that a respondent is fully informed of the scope of the hearing, including specific allegations, if any. If a hearing is required, all notices shall designate a hearing date at least two (2) weeks from the date of the notice, unless such minimum notice period is waived by respondent.

(b) All hearings pursuant to the provisions of this chapter shall be conducted in accordance with the Wyoming Administrative Procedure Act to the extent the provisions are consistent with the procedural requirements contained in this chapter.

26-14-119. Repealed by Laws 1994, ch. 86, § 3.

CHAPTER 15 - THE INSURANCE CONTRACT

ARTICLE 1 - IN GENERAL

26-15-101. Scope of chapter.

(a) This chapter applies to all insurance contracts and annuity contracts except:

(i) Reinsurance;

(ii) Policies or contracts not issued for delivery in this state nor delivered in this state;

(iii) Wet marine and transportation insurance.

26-15-102. Life insurance upon individual or person in whom he has insurable interest; "insurable interest" defined.

(a) Any individual of competent legal capacity may procure or effect an insurance contract upon his own life or body for the benefit of any person. Except as provided in W.S. 26-15-103, no person shall procure or cause to be procured any insurance contract upon the life or body of another individual unless the benefits under the contract are payable to the individual insured or his personal representatives, or to a person having, at the time when the contract is made, an insurable interest in the individual insured.

(b) If the beneficiary, assignee or other payee under any contract made in violation of this section receives from the insurer any benefits thereunder accruing upon the death, disablement or injury of the individual insured, the individual insured or his executor or administrator, as the case may be, may maintain an action to recover the benefits from the person receiving them.

(c) "Insurable interest" as to personal insurance means that any individual has an insurable interest in the life, body and health of himself, and of other persons as follows:

(i) In the case of individuals related closely by blood or by law, a substantial interest engendered by love and affection;

(ii) In the case of other persons, a lawful and substantial economic interest in having the life, health or bodily safety of the individual insured continue, as distinguished from an interest arising only by, or enhanced in value by, the death, disablement or injury of the individual insured; and

(iii) An individual party to a contract or option for the purchase or sale of an interest in a business partnership or firm, or of shares of stock of a closed corporation or of an interest in those shares, has an insurable interest in the life of each individual party to the contract and for the purposes of the contract only, in addition to any insurable interest which otherwise exists as to that individual's life.

(d) An insurer may rely upon all statements, declarations and representations made by an applicant for insurance relative to the applicant's insurable interest in the insured. No insurer incurs legal liability, except as set forth in the policy, by virtue of any untrue statements, declarations or representations relied upon in good faith.

26-15-103. Life insurance for benefit of charitable institutions.

(a) Contracts of life insurance may be made and entered into in which the person paying the consideration for the insurance has no insurable interest in the life of the person insured, if charitable, benevolent, educational or religious institutions are designated irrevocably as a beneficiary but not necessarily the primary beneficiary thereof.

(b) In making a contract as specified in subsection (a) of this section, the person paying the premium shall make and sign the application therefor as owner and shall designate a charitable, benevolent, educational or religious institution irrevocably as the beneficiary or one (1) of the beneficiaries of the policy. The application also shall be signed by the person whose life is to be insured.

(c) The contract is valid and binding among all of the parties thereto, notwithstanding that the owner has no insurable interest in the life of the person insured.

26-15-104. Insurable interest in property; "insurable interest" defined.

(a) No contract of insurance of property or of any interest in property or arising from property is enforceable as to the insurance except for the benefit of persons having an insurable interest in the things insured at the time of the loss.

(b) The measure of an insurable interest in property is the extent to which the insured might be directly or indirectly damnified by loss or impairment thereof.

(c) "Insurable interest" as used in this section means any actual, lawful and substantial economic interest in the safety or preservation of the subject of the insurance free from loss, destruction or pecuniary damage or impairment.

26-15-105. Purchase of life insurance by or for minors or any person of competent legal capacity.

(a) Any person of competent legal capacity may contract for insurance.

(b) Any minor not less than fifteen (15) years of age, notwithstanding his minority, may contract for or own annuities, or insurance, or affirm by novation or otherwise preexisting contracts for annuities or insurance upon his own life, body, health, property, liabilities or other interests, or on the person of another in whom the minor has an insurable interest. The minor, notwithstanding his minority, may exercise all rights and powers with respect to or under any contract for annuity or for insurance upon his own life, body or health, or any contract the minor effects upon his own property, liabilities or other interests, or any contract the minor owns or effects on the person of another, as might be exercised by a person of full legal age, and may at any time surrender his interest in any such contracts and give valid discharge for any benefit accruing or money payable thereunder. The minor, by reason of his minority, is not entitled to rescind, avoid or repudiate the contract, nor to rescind, avoid or repudiate any exercise of a right or privilege thereunder, except that such a minor not otherwise emancipated is not bound by any unperformed agreement to pay, by promissory note or otherwise, any premium on any such annuity or insurance contract.

(c) Any annuity contract or policy of life disability insurance procured by or for a minor under subsection (b) of this section, shall be made payable either to the minor or his estate or to a person having an insurable interest in the minor's life.

26-15-106. Application to be made by individual insured; exceptions.

(a) No life or disability insurance contract upon an individual, except a contract of group life insurance or of group or blanket disability insurance, shall be made or carried out unless at the time of the making of the contract the individual insured, being of competent legal capacity to contract, applies therefor or has consented thereto in writing, except:

(i) A spouse may carry out the insurance upon the other spouse;

(ii) Any person having an insurable interest in the life of a minor, or any person upon whom a minor is dependent for support and maintenance, may carry out insurance upon the life of or pertaining to the minor;

(iii) Family policies may be issued insuring any two (2) or more members of a family on an application signed by either parent, a stepparent or by a husband or wife.

26-15-107. Alteration of application prohibited; exceptions.

No alteration of any written application for any life or disability insurance policy shall be made by any person other than the applicant without his written consent, except that the insurer may make insertions for administrative purposes only in a manner as to indicate clearly that the insertions are not to be ascribed to the applicant.

26-15-108. Application as evidence.

(a) No application for the issuance of any life or disability insurance policy or annuity contract is admissible in evidence in any action relative to the policy or contract, unless a true copy of the application is attached to or otherwise made a part of the policy or contract when issued. This provision does not apply to industrial life insurance policies.

(b) If any life or disability insurance policy delivered in this state is reinstated or renewed, and the insured or the policy beneficiary or assignee makes written request to the insurer for a copy of the reinstatement or renewal application, if any, the insurer, within thirty (30) days after receipt of the request at its home office, shall deliver or mail to the person making the request a copy of the application reproduced by any legible means. If the copy is not delivered or mailed after having been requested, the insurer is precluded from introducing the application in evidence in any action or proceeding based upon or involving the policy or its reinstatement or renewal. In the case of a request from a beneficiary, the time within which the insurer is required to furnish a copy of the application does not begin to run until after receipt of evidence satisfactory to the insurer of the beneficiary's vested interest in the policy or contract.

(c) As to insurance other than life or disability insurance, no application for insurance signed by or on behalf of the insured is admissible in evidence in any action between the insured and the insurer arising out of the policy so applied for, if the insurer fails, at expiration of thirty (30) days after receipt of written demand therefor by or on behalf of the

insured, to furnish to the insured a copy of the application reproduced by any legible means.

26-15-109. Statements in applications as representations and not as warranties; misrepresentations.

(a) Any statements and descriptions in any application for an insurance policy or annuity contract, by or in behalf of the insured or annuitant, are representations and not warranties. Misrepresentations, omissions, concealment of facts and incorrect statements do not prevent a recovery under the policy or contract unless either:

(i) Fraudulent; or

(ii) Material either to the acceptance of the risk, or to the hazard the insurer assumes; or

(iii) The insurer in good faith, if it knew the true facts as required by the application for the policy or contract or otherwise, would not have:

(A) Issued the policy or contract;

(B) Issued it at the same premium rate;

(C) Issued a policy or contract in as large an amount; or

(D) Provided coverage with respect to the hazard resulting in the loss.

26-15-110. Filing and approval of application forms.

(a) No basic insurance policy or annuity contract form, or application form if written application is required and is to be made a part of the policy or contract, or printed rider or endorsement form or form of renewal certificate, shall be delivered or issued for delivery in this state unless the form is filed with and approved by the commissioner or is approved as provided in W.S. 26-15-201. This provision does not apply to surety bonds, or to specially rated inland marine risks, nor to policies, riders, endorsements or forms of unique character designed for and used with relation to insurance upon a particular subject, or which relate to the manner of distribution of benefits or to the reservation of rights and benefits under life or disability insurance policies and are

used at the request of the individual policyholder, contract holder or certificate holder. As to forms for use in property, marine, other than wet marine and transportation insurance, casualty and surety insurance coverages, the filing required by this subsection may be made by advisory and rating organizations on behalf of their members and subscribers. This provision does not prohibit any member or subscriber from filing the forms on its own behalf.

(b) Any filing shall be made not less than forty-five (45) days in advance of any delivery. At the expiration of forty-five (45) days the form filed is approved unless affirmatively approved or disapproved by the commissioner's order. Approval of any form by the commissioner constitutes a waiver of any unexpired portion of the waiting period. The commissioner may extend by not more than an additional forty-five (45) days the period within which he may affirmatively approve or disapprove any form, by giving notice to the insurer of the extension before expiration of the initial forty-five (45) day period. At the expiration of any extended period, and in the absence of prior affirmative approval or disapproval, any form is deemed approved. The commissioner, at any time, after notice and for cause shown, may withdraw any approval.

(c) Any order of the commissioner disapproving a form or withdrawing a previous approval shall state the grounds and the particulars for the withdrawal in such detail as to reasonably inform the insurer. The withdrawal of a previously approved form is effective at the expiration of the period the commissioner prescribes in the notice, but not less than thirty (30) days from the date of the notice.

(d) The commissioner, by order, may exempt from the requirements of this section for so long as he deems proper any insurance document or form or type thereof as specified in the order, to which, in his opinion:

(i) This section may not practicably be applied;

(ii) The filing and approval of which are not desirable or necessary for the public's protection; or

(iii) The document or form or type thereof has been approved under the provisions of the Interstate Insurance Product Regulation Compact as provided in W.S. 26-15-201.

(e) Appeals from the commissioner's orders disapproving a form or withdrawing a previous approval may be taken as provided in W.S. 26-2-125 through 26-2-129.

26-15-111. Filing and approval of application forms; grounds for disapproval.

(a) The commissioner, within forty-five (45) days after filing of any insurance policy, shall disapprove any form filed under W.S. 26-15-110, or withdraw any previous approval thereof, only if:

(i) The form:

(A) Is in any respect in violation of or does not comply with this code;

(B) Contains or incorporates by reference, if the incorporation is otherwise permissible, any inconsistent, ambiguous or misleading clauses, or exceptions and conditions which deceptively affect the risk purported to be assumed in the general coverage of the contract;

(C) Has any title, heading, or other indication of its provisions which is misleading; or

(D) Is printed or otherwise reproduced in such manner as to render any provision of the form substantially illegible; or

(ii) He finds that:

(A) The benefits provided in the policy are unreasonable in relation to the premiums charged; or

(B) The rates or classification are excessive, inadequate or unfairly discriminatory. This paragraph does not apply to any policy form for insurance except those lines of insurance deemed noncompetitive under W.S. 26-14-101 through 26-14-118.

(b) If the commissioner disapproves the insurance policy, the insurer may request a hearing pursuant to the Wyoming Administrative Procedure Act.

26-15-112. Standard and uniform provisions of policies.

(a) Insurance contracts shall contain any standard or uniform provisions required by the applicable provisions of this code pertaining to contracts of particular kinds of insurance. The commissioner may waive the required use of a particular provision in a particular insurance policy form if:

(i) He finds the provision unnecessary for the insured's protection and inconsistent with the policy's purposes; and

(ii) He otherwise approves the policy.

(b) No policy shall contain any provision inconsistent with or contradictory to any standard or uniform provision used or required to be used, but the commissioner may approve any substitute provision which, in his opinion, is not less favorable in any particular to the insured or beneficiary than the provisions otherwise required.

(c) Instead of the provisions required by this code for contracts for particular kinds of insurance, substantially similar provisions required by the law of the domicile of a foreign or alien insurer may be used if the commissioner approves.

(d) A policy issued by a domestic insurer for delivery in another jurisdiction may contain any provision required or permitted by the laws of that jurisdiction.

26-15-113. Contents of policies generally.

(a) Any policy shall specify:

(i) The names of the parties to the contract;

(ii) The subject of the insurance;

(iii) The risks insured against;

(iv) The time when the insurance thereunder takes effect and the period during which the insurance is to continue;

(v) The premium;

(vi) The conditions pertaining to the insurance;

(vii) Benefits payable, if a life or disability insurance contract.

(b) The commissioner, by rule or regulation, may require a life insurer to show in life insurance policies, by reasonable itemization thereof, the amount of premium charged for optional, unique or particular material features or benefits included in or with the policy. The commissioner may also specify what portion of the charge by the insurer for or in connection with title insurance shall be set forth in the policy.

(c) If under the policy the exact amount of premium is determinable only at stated intervals or upon termination of the contract, a statement of the basis and rates upon which the premium is to be determined and paid shall be included.

(d) Subsections (a) through (c) of this section do not apply to surety contracts or to group insurance policies.

26-15-114. Additional policy contents.

(a) A policy may contain additional provisions not inconsistent with this code and which are:

(i) Required to be inserted by the laws of the insurer's domicile;

(ii) Necessary, because of the manner in which the insurer is constituted or operated, in order to state the rights and obligations of the parties to the contract; or

(iii) Desired by the insurer and neither prohibited by law nor in conflict with any provisions required to be included therein.

26-15-115. Adoption of charter and bylaws by reference prohibited.

No policy shall contain any provision purporting to make any portion of the charter, bylaws or other constituent document of the insurer, other than the subscriber's agreement or power of attorney of a reciprocal insurer, a part of the contract unless that portion is set forth in full in the policy. Any policy provision in violation of this section is invalid.

26-15-116. Execution of policies.

(a) Any insurance policy shall be executed in the name of and on behalf of the insurer by its authorized officer, attorney-in-fact, employee or other representative.

(b) A facsimile signature of any executing individual may be used instead of an original signature.

(c) No insurance contract which is otherwise valid shall be rendered invalid by reason of the apparent execution thereof on behalf of the insurer by the imprinted facsimile signature of an individual not authorized to execute as of the date of the policy.

26-15-117. Underwriters' and combination policies.

(a) Two (2) or more authorized insurers may jointly issue, and are jointly and severally liable on, an underwriters' policy bearing their names. Any insurer may issue a policy in the name of an underwriters' department, and the policy shall plainly show the insurer's true name.

(b) Two (2) or more insurers, with the commissioner's approval, may issue a combination policy which shall contain provisions substantially as follows:

(i) That the insurers executing the policy are severally liable for the full amount of any loss or damage, according to the terms of the policy, or for specified percentages or amounts thereof, aggregating the full amount of insurance under the policy; and

(ii) That service of process or of any notice or proof of loss required by the policy, upon any of the insurers executing the policy, constitutes service upon all the insurers.

(c) This section does not apply to cosurety obligations.

26-15-118. Validity and construction of noncomplying policies.

(a) Any policy delivered or issued for delivery to any person in this state in violation of this code, but otherwise binding on the insurer, is valid, but shall be construed as provided in this code.

(b) Any condition, omission or provision not in compliance with this code and contained in any policy, rider or

endorsement, otherwise valid, is not thereby invalid but shall be construed and applied in accordance with the condition, omission or provision as would have applied if it had been in full compliance with this code.

26-15-119. Binders and other contracts for temporary insurance.

(a) Binders or other contracts for temporary insurance may be made orally or in writing and include all the usual terms of the policy as to which the binder is given together with applicable endorsements as are designated in the binder, except as superseded by the terms of the binder.

(b) No binder is valid beyond the issuance of the policy with respect to which it is given, or beyond ninety (90) days from its effective date, whichever period is shorter.

(c) If the policy is not issued, a binder may be extended or renewed beyond the ninety (90) days with the commissioner's written approval or in accordance with rules and regulations relative thereto the commissioner promulgates.

(d) This section does not apply to life or disability insurances.

26-15-120. Delivery of policy; duplicate policies.

If the original policy is delivered or is required to be delivered to or for deposit with any vendor, mortgagee or pledgee of any motor vehicle, and in which policy any interest of the vendee, mortgagor or pledgor in or with reference to the vehicle is insured, a duplicate of the policy setting forth the name and address of the insurer, insurance classification of vehicle, type of coverage, limits of liability, premiums for the types of coverage, and duration of the policy, or memorandum thereof containing the same information, shall be delivered by the vendor, mortgagee or pledgee to each vendee, mortgagor or pledgor named in the policy or coming within the group of persons designated in the policy to be included. If the policy does not provide coverage of legal liability for injury to persons or damage to the property of third parties, a statement of that fact shall be printed, written or stamped conspicuously on the face of the duplicate policy or memorandum. This section does not apply to inland marine floater policies.

26-15-121. Renewal by certificate or endorsement.

(a) Except as provided in subsection (b) of this section, any insurance policy terminating by its terms at a specified expiration date, and not otherwise renewable, may be renewed or extended:

(i) At the insurer's option;

(ii) Upon a currently authorized policy form and at the premium rate then required for the policy;

(iii) For a specific additional period by certificates or by policy endorsement; and

(iv) Without requiring the issuance of a new policy.

(b) A private health benefit plan as defined in W.S. 26-1-102(a)(xxxiii), shall be renewable with respect to all insureds at the option of the insured except in the following cases:

(i) Nonpayment of the required premiums;

(ii) Fraud or misrepresentation by the insured; or

(iii) In the event the insurer elects not to renew an individual private health insurance plan, it may do so only if it elects not to renew all of its individual private health insurance benefit plans issued in this state. In the event the insurer elects not to renew a group private health benefit plan, it may do so only if it elects not to renew all of its group private health benefit plans issued in this state. In either case, the insurer shall:

(A) Provide notice of the decision not to renew coverage to all affected private health benefit plans and to all affected individually insured persons at least one hundred eighty (180) days prior to the nonrenewal of all health benefit plans by the insurer; and

(B) Provide notice of its decision under this paragraph to the commissioner at least three (3) working days prior to providing the notice required under subparagraph (A) of this paragraph.

26-15-122. Assignment of policies.

A policy is assignable or not assignable as provided by its terms. Subject to its terms relating to assignability, any life or disability policy, under the terms of which the beneficiary may be changed upon the sole request of the insured or owner, may be assigned either by pledge or transfer of title, by an assignment executed by the insured or owner alone and delivered to the insurer, whether or not the pledgee or assignee is the insurer. The assignment entitles the insurer to deal with the assignee as the owner or pledgee of the policy in accordance with the terms of the assignment, until the insurer receives at its home office written notice of termination of the assignment or pledge, or written notice by or on behalf of some other person claiming some interest in the policy in conflict with the assignment.

26-15-123. Payment discharges insurer.

If the proceeds of or payments under any life or disability insurance policy or annuity contract are payable in accordance with the terms of the policy or contract, or the exercise of any right or privilege thereunder, and the insurer makes payment thereof in accordance with those terms or in accordance with any written assignment thereof, the person then designated as being entitled thereto is entitled to receive the proceeds or payments and to give full acquittance therefor. The payments fully discharge the insurer from all claims under the policy or contract unless, before payment is made, the insurer receives at its home office written notice by or on behalf of some other person that the other person claims to be entitled to the payment or some interest in the policy or contract.

26-15-124. Claim to be accepted or rejected; attorney's fee.

(a) Claims for benefits under a life, accident or health insurance policy shall be rejected or accepted and paid by the insurer or its agent designated to receive the claims within forty-five (45) days after receipt of the proofs of loss and supporting evidence. Exceptions to the time of forty-five (45) days shall be made for accident and health insurance claims if there is any question as to the validity or the amount of the claim and the question is referred to the Wyoming state medical peer review committee for adjudication. Exceptions shall also be made as authorized by W.S. 26-16-112(a) and 26-52-203.

(b) Claims for benefits under a property or casualty insurance policy shall be rejected or accepted and paid by the

insurer or its agent designated to receive those claims within forty-five (45) days after receipt of the claim and supporting bills.

(c) In any actions or proceedings commenced against any insurance company on any insurance policy or certificate of any type or kind of insurance, or in any case where an insurer is obligated by a liability insurance policy to defend any suit or claim or pay any judgment on behalf of a named insured, if it is determined that the company refuses to pay the full amount of a loss covered by the policy and that the refusal is unreasonable or without cause, any court in which judgment is rendered for a claimant may also award a reasonable sum as an attorney's fee and interest at ten percent (10%) per year.

26-15-125. Repealed by Laws 1993, ch. 1, § 2.

26-15-126. Forms for proof of loss to be furnished.

An insurer, upon written request of any person claiming to have a loss under an insurance contract issued by that insurer, shall furnish forms of proof of loss for completion by the person. The insurer, because of the requirement to furnish forms, does not have any responsibility for or with reference to the completion of the proof or the manner of any completion or attempted completion.

26-15-127. Uniform health insurance claim forms.

The commissioner shall prescribe uniform health insurance claim forms and formats for governmental agencies and health care providers as defined by W.S. 26-40-102(a)(i), which, after January 1, 1997, shall be used by all insurers transacting health insurance in this state and by all governmental agencies and health care providers of this state that require health insurance claim forms or formats for their records.

26-15-128. Insurer's acts not constituting waiver of policy provisions or defenses.

(a) None of the following acts by or on behalf of an insurer constitutes a waiver of any provision of a policy, or of any right, or of any defense of the insurer thereunder or otherwise:

(i) Acknowledgment of the receipt of notice of loss or claim under the policy;

(ii) Furnishing forms for reporting a loss or claim, for giving information relative thereto, or for making proof of loss, or receiving or acknowledging receipt of the forms or proofs completed or uncompleted;

(iii) Investigating any loss or claim under any policy or engaging in negotiations looking toward a possible settlement of any such loss or claim.

26-15-129. Exemption of proceeds; life insurance.

(a) If a policy of insurance is executed by any person on his own life or on another life, in favor of a person other than himself, or except in cases of transfer with intent to defraud creditors, if a policy of life insurance is assigned or in any way made payable to that person, the lawful beneficiary or assignee thereof, other than the insured or the person executing insurance or executors or administrators of the insured or the person executing the insurance, are entitled to its proceeds, including death benefits, cash surrender and loan values, premiums waived and dividends, whether used in reduction of premiums or otherwise, excepting only where the debtor, subsequent to issuance of the policy, has actually elected to receive the dividends in cash, against the creditors and representatives of the insured and of the person executing the policy, and are not liable to be applied by any legal or equitable process to pay any debt or liability of the insured individual or his beneficiary or of any other person having a right under the policy, whether or not:

(i) The right to change the beneficiary is reserved or permitted; and

(ii) The policy is made payable to the person whose life is insured if the beneficiary or assignee predeceases that person, and the proceeds are exempt from all liability for any debt of the beneficiary existing at the time the policy is made available for his use.

(b) However, subject to the statute of limitations, the amount of any premiums paid for insurance with intent to defraud creditors, with interest thereon, shall inure to their benefit from the policy proceeds; but the insurer issuing the policy is discharged of all liability thereon by payment of its proceeds in accordance with its terms, unless before payment the insurer

receives written notice at its home office, by or in behalf of a creditor of:

(i) A claim to recover for transfer made or premiums paid with intent to defraud creditors;

(ii) The amount claimed along with facts as will assist the insurer to ascertain the particular policy.

(c) For the purposes of subsections (a) and (b) of this section, a policy is payable to a person other than the insured if and to the extent that a facility-of-payment clause or similar clause in the policy permits the insurer to discharge its obligation after the death of the individual insured by paying the death benefits to a person as permitted by the clause.

26-15-130. Exemption of proceeds; disability insurance.

Except as otherwise provided by the policy or contract, the proceeds of all contracts of disability insurance and of provisions specifying benefits because of the insured's disability, which are supplemental to any life insurance or annuity contracts executed, are exempt from all liability for any debt of the insured and from any debt of the beneficiary existing at the time the proceeds are made available for his use.

26-15-131. Exemption of proceeds; group insurance.

(a) A policy of group life insurance or group disability insurance or the proceeds thereof, including death benefits, cash surrender and loan values, premiums waived and dividends, whether used in reduction of premiums or otherwise, excepting only where the debtor, subsequent to issuance of the policy, has actually elected to receive the dividends in cash, payable to the individual insured or to the named beneficiary are not liable to be applied by any legal or equitable process to pay any debt or liability of the insured individual or his beneficiary or of any other person having a right under the policy. The proceeds, when not made payable to a named beneficiary, or to a third person pursuant to a facility-of-payment clause, do not constitute a part of the insured individual's estate for the payment of his debts.

(b) This section does not apply to group insurance issued pursuant to this code to a creditor covering his debtors, to the

extent that the proceeds are applied to payment of the obligation for the purpose of which the insurance is issued.

26-15-132. Exemption of proceeds; annuity contracts; assignability of rights.

(a) The benefits, rights, privileges and options which under any annuity contract issued are due or prospectively due the annuitant, are not subject to execution nor is the annuitant compelled to exercise any such rights, powers or options. Creditors are not allowed to interfere with or terminate the contract, except:

(i) As to amounts paid for or as premium on the annuity with intent to defraud creditors, with interest thereon, and of which the creditor gives the insurer written notice at its home office prior to the making of the payment to the annuitant out of which the creditor seeks to recover, which notice shall specify:

(A) The amount claimed or facts to enable the ascertainment of the amount; and

(B) Facts to enable the insurer to ascertain the annuity contract, the annuitant and the payment sought to be avoided on the ground of fraud.

(ii) The total exemption of benefits presently due and payable to any annuitant periodically or at stated times under all annuity contracts under which he is an annuitant shall not at any time exceed three hundred fifty dollars ($350.00) per month for the length of time represented by the installments, and any periodic payments in excess of three hundred fifty dollars ($350.00) per month are subject to garnishee execution to the same extent as are wages and salaries;

(iii) If the total benefits presently due and payable to any annuitant under any annuity contracts at any time exceed three hundred fifty dollars ($350.00) per month, the court may order the annuitant to pay to a judgment creditor or apply on the judgment, in installments, that portion of the excess benefits as to the court appear just and proper, after regard for the reasonable requirements of the judgment debtor and his family, if dependent upon him, as well as any payments required to be made by the annuitant to other creditors under prior court order.

(b) If the contract provides, the benefits, rights, privileges or options accruing under that contract to a beneficiary or assignee are not transferable nor subject to commutation, and if the benefits are payable periodically or at stated times, the same exemptions and exceptions contained in this section for the annuitant, apply to the beneficiary or assignee.

26-15-133. Retention of proceeds of policy by company.

(a) Any life insurer may hold the proceeds of any life or endowment insurance or annuity contract it issues:

(i) Upon the terms and restrictions as to revocation by the insured and control by beneficiaries;

(ii) With the exemptions from legal process and the claims of creditors of beneficiaries, other than the insured; and

(iii) Upon any other terms and conditions, regardless of the time and manner of payment of proceeds, agreed to in writing by the insurer and the insured or beneficiary.

(b) The insurer is not required to segregate funds held under subsection (a) of this section but may hold them as a part of its general corporate assets.

(c) The provisions of this section do not impair or affect any rights of creditors under W.S. 26-15-129 or 26-15-132.

26-15-134. Venue of suits against insurers.

Suit upon causes of action arising within this state against an insurer over an insurance contract shall be brought in the county where the cause of action arose or in the county where the policyholder instituting the action resides.

26-15-135. Coverage of children.

(a) No insurance company, multi-employer trust or other provider of an individual, group or blanket health insurance product in this state shall:

(i) Refuse to accept and honor an otherwise valid claim for a covered service which is filed by either parent of a covered child, or by the department of family services in the

case of an assignment under W.S. 20-6-106, who submits valid copies of medical bills;

(ii) Refuse to provide medical insurance coverage of a child under the health plan of the child's parent on the grounds that:

(A) The child was born out of wedlock;

(B) The child is not claimed as a dependent on the parent's federal tax return; or

(C) The child does not reside with the parent or in the insurer's service area.

(iii) Refuse to provide medical insurance coverage for an otherwise insurable child under the policy if the child for whom the claim is made is presumed to be the natural child of the insured under W.S. 14-2-504 or 14-2-822.

(b) Where a child has health coverage through an insurer of a noncustodial parent or a parent sharing custody or temporary control of the child the insurer shall:

(i) Provide such information to either parent sharing custody or temporary control of the child as may be necessary for the child to obtain benefits through that coverage;

(ii) Permit either parent sharing custody or temporary control of the child, or the provider with either parent's approval, to submit claims for covered services without the approval of the other parent; and

(iii) Make payments on claims submitted in accordance with paragraph (ii) of this subsection directly to the parent who paid for the services, the provider or the department of health as administrator of the Wyoming Medical Assistance and Services Act.

(c) Where a parent is required by a court or administrative order to provide health coverage for a child and the parent is eligible for family health coverage, the insurer shall be required:

(i) To permit the parent to enroll under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions;

(ii) If the parent is enrolled but fails to make application to obtain coverage for the child, to enroll the child under family coverage upon application of the child's other parent, the department of health in administering the Wyoming Medical Assistance and Services Act, or the department of family services in administering the child support enforcement program;

(iii) To complete and return the plan administrator response in conjunction with the national medical support notice to the department of family services within forty (40) business days after the date of the notice; and

(iv) Not to disenroll or eliminate coverage of the child unless the insurer is provided satisfactory written evidence that:

(A) The court or administrative order is no longer in effect; or

(B) The child is or will be enrolled in comparable health coverage through another insurer which will take effect not later than the effective date of disenrollment.

(d) An insurer may not impose requirements on a state agency, which has been assigned the rights of an individual eligible for medical assistance under the Wyoming Medical Assistance and Services Act and covered for health benefits from the insurer, that are different from requirements applicable to an agent or assignee of any other individual so covered.

26-15-136. Assignment of insurance proceeds to doctor, hospital or state agency; lien for state care; notice of lien.

(a) Whenever a contract by a third party agency provides for payment to a beneficiary under the contract for expenses incurred by him for medical, surgical or hospital care, the beneficiary shall assign the benefits of the contract to the Wyoming department of health or any doctor or hospital, or other practitioner rendering the care in an amount equal to the value of the care rendered. Notification sent by registered or certified mail to the third party agency, with a copy to the insured, shall provide authority for the payment directly by the third party agency to the assignee. The state shall have a lien, in an amount equal to the care rendered, on the proceeds of the contracts for care rendered by any hospital, institution

or other facility, written notice of which shall provide authority for payment directly by the third party agency to the state.

(b) Whenever there is in existence a contract between an insurer and an insured for payment to, or on behalf of, an applicant or recipient of medical assistance under the contract for expenses incurred by the applicant or recipient for medical services, including physician services, nursing services, pharmaceutical services, surgical care and hospital care, the assignment of the benefits of the contract by the applicant or recipient or a legally liable party shall, upon receipt of notice from the assignee, provide authority for payment by the insurer directly to the assignee. If notice is provided by the assignee to the insurer in accordance with the provisions of W.S 42-4-204, the insurer shall be liable to the assignee for any amount payable to the assignee under the contract.

26-15-137. Time limit to seek reimbursement for health insurance overpayments.

An action or request for reimbursement of any overpayment of a health insurance claim to a health care provider pursuant to any health insurance contract shall be brought not more than two (2) years after the date the claim was paid. No insurer, assignee of the insurer, or other person, whether acting for himself or another in connection with a health insurance transaction, shall make any claim or seek recovery for reimbursement of any overpayment to a health care provider pursuant to any health insurance contract more than two (2) years after the date the claim was paid, unless the claim was fraudulent.

ARTICLE 2 - INTERSTATE INSURANCE PRODUCT REGULATION

26-15-201. Interstate insurance product regulation compact.

The Interstate Insurance Product Regulation Compact is hereby enacted into law and entered into on behalf of this state with any and all other states legally joining therein in a form substantially as follows:

INTERSTATE INSURANCE PRODUCT REGULATION COMPACT

ARTICLE I

Purposes

(a) The purposes of this compact are, through means of joint and cooperative action among the compacting states:

(i) To promote and protect the interest of consumers of individual and group annuity, life insurance, disability income and long-term care insurance products;

(ii) To develop uniform standards for insurance products covered under the compact;

(iii) To establish a central clearinghouse to receive and provide prompt review of insurance products covered under the compact and, in certain cases, advertisements related thereto, submitted by insurers authorized to do business in one or more compacting states;

(iv) To give appropriate regulatory approval to those product filings and advertisements satisfying the applicable uniform standard;

(v) To improve coordination of regulatory resources and expertise between state insurance departments regarding the setting of uniform standards and review of insurance products covered under the compact;

(vi) To create the interstate insurance product regulation commission; and

(vii) To perform these and such other related functions as may be consistent with the state regulation of the business of insurance.

ARTICLE II

Definitions

(a) Notwithstanding W.S. 26-1-102, for purposes of this compact:

(i) "Advertisement" means any material designed to create public interest in a product, or induce the public to purchase, increase, modify, reinstate, borrow on, surrender, replace or retain a policy, as more specifically defined in the rules and operating procedures of the commission;

(ii) "Bylaws" means those bylaws established by the commission for its governance, or for directing or controlling the commission's actions or conduct;

(iii) "Compacting state" means any state which has enacted this compact legislation and which has not withdrawn pursuant to article XIV, section 1, or been terminated pursuant to article XIV, section 2;

(iv) "Commission" means the "interstate insurance product regulation commission" established by this compact;

(v) "Commissioner" means the chief insurance regulatory official of a state including, but not limited to commissioner, superintendent, director or administrator;

(vi) "Domiciliary state" means the state in which an insurer is incorporated or organized or, in the case of an alien insurer, its state of entry;

(vii) "Insurer" means any entity licensed by a state to issue contracts of insurance for any of the lines of insurance covered by this compact;

(viii) "Member" means the person chosen by a compacting state as its representative to the commission, or his or her designee;

(ix) "Noncompacting state" means any state which is not at the time a compacting state;

(x) "Operating procedures" mean procedures promulgated by the commission implementing a rule, uniform standard or a provision of this compact;

(xi) "Product" means the form of a policy or contract, including any application, endorsement or related form which is attached to and made a part of the policy or contract, and any evidence of coverage or certificate, for an individual or group annuity, life insurance, disability income or long-term care insurance product that an insurer is authorized to issue;

(xii) "Rule" means a statement of general or particular applicability and future effect promulgated by the commission, including a uniform standard developed pursuant to article VII of this compact, designed to implement, interpret or prescribe law or policy or describing the organization,

procedure or practice requirements of the commission, which shall have the force and effect of law in the compacting states;

(xiii) "State" means any state, district or territory of the United States of America;

(xiv) "Third-party filer" means an entity that submits a product filing to the commission on behalf of an insurer;

(xv) "Uniform standard" means a standard adopted by the commission for a product line, pursuant to article VII of this compact, and shall include all of the product requirements in aggregate, provided, that each uniform standard shall be construed, whether express or implied, to prohibit the use of any inconsistent, misleading or ambiguous provisions in a product and the form of the product made available to the public shall not be unfair, inequitable or against public policy as determined by the commission.

ARTICLE III

Establishment of the commission and venue

(a) The compacting states hereby create and establish a joint public agency known as the "interstate insurance product regulation commission." Pursuant to article IV, the commission will have the power to develop uniform standards for product lines, receive and provide prompt review of products filed therewith and give approval to those product filings satisfying applicable uniform standards; provided, it is not intended for the commission to be the exclusive entity for receipt and review of insurance product filings. Nothing herein shall prohibit any insurer from filing its product in any state wherein the insurer is licensed to conduct the business of insurance; and any such filing shall be subject to the laws of the state where filed.

(b) The commission is a body corporate and politic, and an instrumentality of the compacting states.

(c) The commission is solely responsible for its liabilities except as otherwise specifically provided in this compact.

(d) Venue is proper and judicial proceedings by or against the commission shall be brought solely and exclusively in a

court of competent jurisdiction where the principal office of the commission is located.

ARTICLE IV

Powers of the commission

(a) The commission shall have the following powers:

(i) To promulgate rules, pursuant to article VII of this compact, which shall have the force and effect of law and shall be binding in the compacting states to the extent and in the manner provided in this compact;

(ii) To exercise its rulemaking authority and establish reasonable uniform standards for products covered under the compact, and advertisement related thereto, which shall have the force and effect of law and shall be binding in the compacting states, but only for those products filed with the commission, provided, that a compacting state shall have the right to opt out of such uniform standard pursuant to article VII, to the extent and in the manner provided in this compact, and, provided further, that any uniform standard established by the commission for long-term care insurance products may provide the same or greater protections for consumers as, but shall not provide less than, those protections set forth in the National Association of Insurance Commissioners' Long-Term Care Insurance Model Act and Long-Term Care Insurance Model Regulation, respectively, adopted as of 2001. The commission shall consider whether any subsequent amendments to the National Association Of Insurance Commissioners' Long-Term Care Insurance Model Act or Long-Term Care Insurance Model Regulation adopted by the national association of insurance commissioners require amending of the uniform standards established by the commission for long-term care insurance products;

(iii) To receive and review in an expeditious manner products filed with the commission, and rate filings for disability income and long-term care insurance products, and give approval of those products and rate filings that satisfy the applicable uniform standard, where such approval shall have the force and effect of law and be binding on the compacting states to the extent and in the manner provided in the compact;

(iv) To receive and review in an expeditious manner advertisement relating to long-term care insurance products for which uniform standards have been adopted by the commission, and

give approval to all advertisement that satisfies the applicable uniform standard. For any product covered under this compact, other than long-term care insurance products, the commission shall have the authority to require an insurer to submit all or any part of its advertisement with respect to that product for review or approval prior to use, if the commission determines that the nature of the product is such that an advertisement of the product could have the capacity or tendency to mislead the public. The actions of commission as provided in this section shall have the force and effect of law and shall be binding in the compacting states to the extent and in the manner provided in the compact;

(v) To exercise its rulemaking authority and designate products and advertisement that may be subject to a self-certification process without the need for prior approval by the commission;

(vi) To promulgate operating procedures, pursuant to article VII of this compact, which shall be binding in the compacting states to the extent and in the manner provided in this compact;

(vii) To bring and prosecute legal proceedings or actions in its name as the commission; provided, that the standing of any state insurance department to sue or be sued under applicable law shall not be affected;

(viii) To issue subpoenas requiring the attendance and testimony of witnesses and the production of evidence;

(ix) To establish and maintain offices;

(x) To purchase and maintain insurance and bonds;

(xi) To borrow, accept or contract for services of personnel, including, but not limited to, employees of a compacting state;

(xii) To hire employees, professionals or specialists, and elect or appoint officers, and to fix their compensation, define their duties and give them appropriate authority to carry out the purposes of the compact, and determine their qualifications; and to establish the commission's personnel policies and programs relating to, among other things, conflicts of interest, rates of compensation and qualifications of personnel;

(xiii) To accept any and all appropriate donations and grants of money, equipment, supplies, materials and services, and to receive, utilize and dispose of the same; provided that at all times the commission shall strive to avoid any appearance of impropriety;

(xiv) To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve or use, any property, real, personal or mixed; provided that at all times the commission shall strive to avoid any appearance of impropriety;

(xv) To sell, convey, mortgage, pledge, lease, exchange, abandon or otherwise dispose of any property, real, personal or mixed;

(xvi) To remit filing fees to compacting states as may be set forth in the bylaws, rules or operating procedures;

(xvii) To enforce compliance by compacting states with rules, uniform standards, operating procedures and bylaws;

(xviii) To provide for dispute resolution among compacting states;

(xix) To advise compacting states on issues relating to insurers domiciled or doing business in noncompacting jurisdictions, consistent with the purposes of this compact;

(xx) To provide advice and training to those personnel in state insurance departments responsible for product review, and to be a resource for state insurance departments;

(xxi) To establish a budget and make expenditures;

(xxii) To borrow money;

(xxiii) To appoint committees, including advisory committees comprising members, state insurance regulators, state legislators or their representatives, insurance industry and consumer representatives and such other interested persons as may be designated in the bylaws;

(xxiv) To provide and receive information from, and to cooperate with law enforcement agencies;

(xxv) To adopt and use a corporate seal; and

(xxvi) To perform such other functions as may be necessary or appropriate to achieve the purposes of this compact consistent with the state regulation of the business of insurance.

ARTICLE V

Organization of the commission

(a) Membership, voting and bylaws shall be as follows:

(i) Each compacting state shall have and be limited to one (1) member. Each member shall be qualified to serve in that capacity pursuant to applicable law of the compacting state. Any member may be removed or suspended from office as provided by the law of the state from which he or she shall be appointed. Any vacancy occurring in the commission shall be filled in accordance with the laws of the compacting state wherein the vacancy exists. Nothing herein shall be construed to affect the manner in which a compacting state determines the election or appointment and qualification of its own commissioner;

(ii) Each member shall be entitled to one (1) vote and shall have an opportunity to participate in the governance of the commission in accordance with the bylaws. Notwithstanding any provision herein to the contrary, no action of the commission with respect to the promulgation of a uniform standard shall be effective unless two-thirds (2/3) of the members vote in favor thereof;

(iii) The commission shall, by a majority of the members, prescribe bylaws to govern its conduct as may be necessary or appropriate to carry out the purposes, and exercise the powers, of the compact, including, but not limited to:

(A) Establishing the fiscal year of the commission;

(B) Providing reasonable procedures for appointing and electing members, as well as holding meetings, of the management committee;

(C) Providing reasonable standards and procedures:

(I) For the establishment and meetings of other committees; and

(II) Governing any general or specific delegation of any authority or function of the commission.

(D) Providing reasonable procedures for calling and conducting meetings of the commission that consist of a majority of commission members, ensuring reasonable advance notice of each such meeting and providing for the right of citizens to attend each such meeting with enumerated exceptions designed to protect the public's interest, the privacy of individuals, and insurers' proprietary information, including trade secrets. The commission may meet in camera only after a majority of the entire membership votes to close a meeting en toto or in part. As soon as practicable, the commission must make public:

(I) A copy of the vote to close the meeting revealing the vote of each member with no proxy votes allowed; and

(II) Votes taken during such meeting.

(E) Establishing the titles, duties and authority and reasonable procedures for the election of the officers of the commission;

(F) Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the commission. Notwithstanding any civil service or other similar laws of any compacting state, the bylaws shall exclusively govern the personnel policies and programs of the commission;

(G) Promulgating a code of ethics to address permissible and prohibited activities of commission members and employees; and

(H) Providing a mechanism for winding up the operations of the commission and the equitable disposition of any surplus funds that may exist after the termination of the compact after the payment and/or reserving of all of its debts and obligations; and

(iv) The commission shall publish its bylaws in a convenient form and file a copy thereof and a copy of any amendment thereto, with the appropriate agency or officer in each of the compacting states.

(b) Management committee, officers and personnel shall be as follows:

(i) A management committee comprising no more than fourteen (14) members shall be established as follows:

(A) One (1) member from each of the six (6) compacting states with the largest premium volume for individual and group annuities, life, disability income and long-term care insurance products, determined from the records of the national association of insurance commissioners for the prior year;

(B) Four (4) members from those compacting states with at least two percent (2%) of the market based on the premium volume described above, other than the six (6) compacting states with the largest premium volume, selected on a rotating basis as provided in the bylaws; and

(C) Four (4) members from those compacting states with less than two percent (2%) of the market, based on the premium volume described above, with one (1) selected from each of the four (4) zone regions of the national association of insurance commissioners as provided in the bylaws.

(ii) The management committee shall have such authority and duties as may be set forth in the bylaws, including but not limited to:

(A) Managing the affairs of the commission in a manner consistent with the bylaws and purposes of the commission;

(B) Establishing and overseeing an organizational structure within, and appropriate procedures for, the commission to provide for the creation of uniform standards and other rules, receipt and review of product filings, administrative and technical support functions, review of decisions regarding the disapproval of a product filing, and the review of elections made by a compacting state to opt out of a uniform standard; provided that a uniform standard shall not be submitted to the compacting states for adoption unless approved by two-thirds (2/3) of the members of the management committee;

(C) Overseeing the offices of the commission; and

(D) Planning, implementing and coordinating communications and activities with other state, federal and local government organizations in order to advance the goals of the commission.

(iii) The commission shall elect annually officers from the management committee, with each having such authority and duties, as may be specified in the bylaws;

(iv) The management committee may, subject to the approval of the commission, appoint or retain an executive director for such period, upon such terms and conditions and for such compensation as the commission may deem appropriate. The executive director shall serve as secretary to the commission, but shall not be a member of the commission. The executive director shall hire and supervise such other staff as may be authorized by the commission.

(c) Legislative and advisory committees shall be as follows:

(i) A legislative committee comprising state legislators or their designees shall be established to monitor the operations of, and make recommendations to, the commission, including the management committee; provided that the manner of selection and term of any legislative committee member shall be as set forth in the bylaws. Prior to the adoption by the commission of any uniform standard, revision to the bylaws, annual budget or other significant matter as may be provided in the bylaws, the management committee shall consult with and report to the legislative committee;

(ii) The commission shall establish two (2) advisory committees, one (1) of which shall comprise consumer representatives independent of the insurance industry, and the other comprising insurance industry representatives;

(iii) The commission may establish additional advisory committees as its bylaws may provide for the carrying out of its functions.

(d) Corporate records of the commission shall be as follows:

(i) The commission shall maintain its corporate books and records in accordance with the bylaws.

(e) Qualified immunity, defense and indemnification shall be as follows:

(i) The members, officers, executive director, employees and representatives of the commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of commission employment, duties or responsibilities; provided, that nothing in this paragraph shall be construed to protect any such person from suit and liability for any damage, loss, injury or liability caused by the intentional or willful and wanton misconduct of that person;

(ii) The commission shall defend any member, officer, executive director, employee or representative of the commission in any civil action seeking to impose liability arising out of any actual or alleged act, error or omission that occurred within the scope of commission employment, duties or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of commission employment, duties or responsibilities, provided, that nothing herein shall be construed to prohibit that person from retaining his or her own counsel, and provided further, that the actual or alleged act, error or omission did not result from that person's intentional or willful and wanton misconduct;

(iii) The commission shall indemnify and hold harmless any member, officer, executive director, employee or representative of the commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of commission employment, duties or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of commission employment, duties or responsibilities, provided, that the actual or alleged act, error or omission did not result from the intentional or willful and wanton misconduct of that person.

ARTICLE VI

Meetings and acts of the commission

(a) The commission shall meet and take such actions as are consistent with the provisions of this compact and the bylaws.

(b) Each member of the commission shall have the right and power to cast a vote to which that compacting state is entitled and to participate in the business and affairs of the commission. A member shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for members' participation in meetings by telephone or other means of communication.

(c) The commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the bylaws.

ARTICLE VII

Rules and operating procedures:

rulemaking functions of the commission

and opting out of uniform standards

(a) Rulemaking authority. The commission shall promulgate reasonable rules, including uniform standards, and operating procedures in order to effectively and efficiently achieve the purposes of this compact. Notwithstanding the foregoing, in the event the commission exercises its rulemaking authority in a manner that is beyond the scope of the purposes of this compact, or the powers granted hereunder, then such an action by the commission shall be invalid and have no force and effect.

(b) Rulemaking procedure. Rules and operating procedures shall be made pursuant to a rulemaking process that conforms to the Model State Administrative Procedure Act of 1981 as amended, as may be appropriate to the operations of the commission. Before the commission adopts a uniform standard, the commission shall give written notice to the relevant state legislative committee in each compacting state responsible for insurance issues of its intention to adopt the uniform standard. The commission in adopting a uniform standard shall consider fully all submitted materials and issue a concise explanation of its decision.

(c) Effective date and opt out of a uniform standard. A uniform standard shall become effective ninety (90) days after its promulgation by the commission or such later date as the commission may determine; provided, however, that a compacting state may opt out of a uniform standard as provided in this article. "Opt out" shall be defined as any action by a compacting state to decline to adopt or participate in a promulgated uniform standard. All other rules and operating procedures, and amendments thereto, shall become effective as of the date specified in each rule, operating procedure or amendment.

(d) Opt out procedure. A compacting state may opt out of a uniform standard, either by legislation or regulation duly promulgated by the insurance department under the compacting state's administrative procedure act. If a compacting state elects to opt out of a uniform standard by regulation, it must:

(i) Give written notice to the commission no later than ten (10) business days after the uniform standard is promulgated, or at the time the state becomes a compacting state; and

(ii) Find that the uniform standard does not provide reasonable protections to the citizens of the state, given the conditions in the state. The commissioner shall make specific findings of fact and conclusions of law, based on a preponderance of the evidence, detailing the conditions in the state which warrant a departure from the uniform standard and determining that the uniform standard would not reasonably protect the citizens of the state. The commissioner must consider and balance the following factors and find that the conditions in the state and needs of the citizens of the state outweigh:

(A) The intent of the legislature to participate in, and the benefits of, an interstate agreement to establish national uniform consumer protections for the products subject to this compact; and

(B) The presumption that a uniform standard adopted by the commission provides reasonable protections to consumers of the relevant product.

(iii) Notwithstanding the foregoing, a compacting state may, at the time of its enactment of this compact,

prospectively opt out of all uniform standards involving long-term care insurance products by expressly providing for such opt out in the enacted compact, and such an opt out shall not be treated as a material variance in the offer or acceptance of any state to participate in this compact. Such an opt out shall be effective at the time of enactment of this compact by the compacting state and shall apply to all existing uniform standards involving long-term care insurance products and those subsequently promulgated.

(e) Effect of opt out is as follows:

(i) If a compacting state elects to opt out of a uniform standard, the uniform standard shall remain applicable in the compacting state electing to opt out until such time the opt out legislation is enacted into law or the regulation opting out becomes effective;

(ii) Once the opt out of a uniform standard by a compacting state becomes effective as provided under the laws of that state, the uniform standard shall have no further force and effect in that state unless and until the legislation or regulation implementing the opt out is repealed or otherwise becomes ineffective under the laws of the state. If a compacting state opts out of a uniform standard after the uniform standard has been made effective in that state, the opt out shall have the same prospective effect as provided under article XIV for withdrawals.

(f) Stay of uniform standard. If a compacting state has formally initiated the process of opting out of a uniform standard by regulation, and while the regulatory opt out is pending, the compacting state may petition the commission, at least fifteen (15) days before the effective date of the uniform standard, to stay the effectiveness of the uniform standard in that state. The commission may grant a stay if it determines the regulatory opt out is being pursued in a reasonable manner and there is a likelihood of success. If a stay is granted or extended by the commission, the stay or extension thereof may postpone the effective date by up to ninety (90) days, unless affirmatively extended by the commission; provided, a stay may not be permitted to remain in effect for more than one (1) year unless the compacting state can show extraordinary circumstances which warrant a continuance of the stay, including, but not limited to, the existence of a legal challenge which prevents the compacting state from opting out. A stay may be terminated

by the commission upon notice that the rulemaking process has been terminated.

(g) Not later than thirty (30) days after a rule or operating procedure is promulgated, any person may file a petition for judicial review of the rule or operating procedure; provided, that the filing of such a petition shall not stay or otherwise prevent the rule or operating procedure from becoming effective unless the court finds that the petitioner has a substantial likelihood of success. The court shall give deference to the actions of the commission consistent with applicable law and shall not find the rule or operating procedure to be unlawful if the rule or operating procedure represents a reasonable exercise of the commission's authority.

ARTICLE VIII

Commission records and enforcement

(a) The commission shall promulgate rules establishing conditions and procedures for public inspection and copying of its information and official records, except such information and records involving the privacy of individuals and insurers' trade secrets. The commission may promulgate additional rules under which it may make available to federal and state agencies, including law enforcement agencies, records and information otherwise exempt from disclosure, and may enter into agreements with such agencies to receive or exchange information or records subject to nondisclosure and confidentiality provisions.

(b) Except as to privileged records, data and information, the laws of any compacting state pertaining to confidentiality or nondisclosure shall not relieve any compacting state commissioner of the duty to disclose any relevant records, data or information to the commission; provided, that disclosure to the commission shall not be deemed to waive or otherwise affect any confidentiality requirement; and further provided, that, except as otherwise expressly provided in this compact, the commission shall not be subject to the compacting state's laws pertaining to confidentiality and nondisclosure with respect to records, data and information in its possession. Confidential information of the commission shall remain confidential after such information is provided to any commissioner.

(c) The commission shall monitor compacting states for compliance with duly adopted bylaws, rules, including uniform standards, and operating procedures. The commission shall

notify any noncomplying compacting state in writing of its noncompliance with commission bylaws, rules or operating procedures. If a noncomplying compacting state fails to remedy its noncompliance within the time specified in the notice of noncompliance, the compacting state shall be deemed to be in default as set forth in article XIV.

(d) The commissioner of any state in which an insurer is authorized to do business, or is conducting the business of insurance, shall continue to exercise his authority to oversee the market regulation of the activities of the insurer in accordance with the provisions of the state's law. The commissioner's enforcement of compliance with the compact is governed by the following provisions:

(i) With respect to the commissioner's market regulation of a product or advertisement that is approved or certified to the commission, the content of the product or advertisement shall not constitute a violation of the provisions, standards or requirements of the compact except upon a final order of the commission, issued at the request of a commissioner after prior notice to the insurer and an opportunity for hearing before the commission;

(ii) Before a commissioner may bring an action for violation of any provision, standard or requirement of the compact relating to the content of an advertisement not approved or certified to the commission, the commission, or an authorized commission officer or employee, must authorize the action. However, authorization pursuant to this paragraph does not require notice to the insurer, opportunity for hearing or disclosure of requests for authorization or records of the commission's action on such requests.

ARTICLE IX

Dispute resolution

The commission shall attempt, upon the request of a member, to resolve any disputes or other issues that are subject to this compact and which may arise between two (2) or more compacting states, or between compacting states and noncompacting states, and the commission shall promulgate an operating procedure providing for resolution of such disputes.

ARTICLE X

Product filing and approval

(a) Insurers and third-party filers seeking to have a product approved by the commission shall file the product with, and pay applicable filing fees to, the commission. Nothing in this compact shall be construed to restrict or otherwise prevent an insurer from filing its product with the insurance department in any state wherein the insurer is licensed to conduct the business of insurance, and such filing shall be subject to the laws of the states where filed.

(b) The commission shall establish appropriate filing and review processes and procedures pursuant to commission rules and operating procedures. Notwithstanding any provision herein to the contrary, the commission shall promulgate rules to establish conditions and procedures under which the commission will provide public access to product filing information. In establishing such rules, the commission shall consider the interests of the public in having access to such information, as well as protection of personal medical and financial information and trade secrets, that may be contained in a product filing or supporting information.

(c) Any product approved by the commission may be sold or otherwise issued in those compacting states for which the insurer is legally authorized to do business.

ARTICLE XI

Review of commission decisions regarding filings

(a) Not later than thirty (30) days after the commission has given notice of a disapproved product or advertisement filed with the commission, the insurer or third-party filer whose filing was disapproved may appeal the determination to a review panel appointed by the commission. The commission shall promulgate rules to establish procedures for appointing such review panels and provide for notice and hearing. An allegation that the commission, in disapproving a product or advertisement filed with the commission, acted arbitrarily, capriciously or in a manner that is an abuse of discretion or otherwise not in accordance with the law, is subject to judicial review in accordance with article III, subsection (d).

(b) The commission shall have authority to monitor, review and reconsider products and advertisements subsequent to their filing or approval upon a finding that the product does not meet

the relevant uniform standard. Where appropriate, the commission may withdraw or modify its approval after proper notice and hearing, subject to the appeal process in subsection (a) of this article.

Article XII

Finance

(a) The commission shall pay or provide for the payment of the reasonable expenses of its establishment and organization. To fund the cost of its initial operations, the commission may accept contributions and other forms of funding from the national association of insurance commissioners, compacting states and other sources. Contributions and other forms of funding from other sources shall be of such a nature that the independence of the commission concerning the performance of its duties shall not be compromised.

(b) The commission shall collect a filing fee from each insurer and third-party filer filing a product with the commission to cover the cost of the operations and activities of the commission and its staff in a total amount sufficient to cover the commission's annual budget.

(c) The commission's budget for a fiscal year shall not be approved until it has been subject to notice and comment as set forth in article VII of this compact.

(d) The commission shall be exempt from all taxation in and by the compacting states.

(e) The commission shall not pledge the credit of any compacting state, except by and with the appropriate legal authority of that compacting state.

(f) The commission shall keep complete and accurate accounts of all its internal receipts, including grants and donations, and disbursements of all funds under its control. The internal financial accounts of the commission shall be subject to the accounting procedures established under its bylaws. The financial accounts and reports including the system of internal controls and procedures of the commission shall be audited annually by an independent certified public accountant. Upon the determination of the commission, but no less frequently than every three (3) years, the review of the independent auditor shall include a management and performance audit of the

commission. The commission shall make an annual report to the governor and legislature of the compacting states, which shall include a report of the independent audit. The commission's internal accounts shall not be confidential and such materials may be shared with the commissioner of any compacting state upon request provided, however, that any work papers related to any internal or independent audit and any information regarding the privacy of individuals and insurers' proprietary information, including trade secrets, shall remain confidential.

(g) No compacting state shall have any claim to or ownership of any property held by or vested in the commission or to any commission funds held pursuant to the provisions of this compact.

ARTICLE XIII

Compacting states, effective date and amendment

(a) Any state is eligible to become a compacting state.

(b) The compact shall become effective and binding upon legislative enactment of the compact into law by two (2) compacting states; provided, the commission shall become effective for purposes of adopting uniform standards for, reviewing, and giving approval or disapproval of, products filed with the commission that satisfy applicable uniform standards only after twenty-six (26) states are compacting states or, alternatively, by states representing greater than forty percent (40%) of the premium volume for life insurance, annuity, disability income and long-term care insurance products, based on records of the national association of insurance commissioners for the prior year. Thereafter, it shall become effective and binding as to any other compacting state upon enactment of the compact into law by that state.

(c) Amendments to the compact may be proposed by the commission for enactment by the compacting states. No amendment shall become effective and binding upon the commission and the compacting states unless and until all compacting states enact the amendment into law.

ARTICLE XIV

Withdrawal, default and termination

(a) Withdrawal shall be as follows:

(i) Once effective, the compact shall continue in force and remain binding upon each and every compacting state; provided, that a compacting state may withdraw from the compact ("withdrawing state") by enacting a statute specifically repealing the statute which enacted the compact into law;

(ii) The effective date of withdrawal is the effective date of the repealing statute. However, the withdrawal shall not apply to any product filings approved or self-certified, or any advertisement of such products, on the date the repealing statute becomes effective, except by mutual agreement of the commission and the withdrawing state unless the approval is rescinded by the withdrawing state as provided in paragraph (v) of this subsection;

(iii) The commissioner of the withdrawing state shall immediately notify the management committee in writing upon the introduction of legislation repealing this compact in the withdrawing state;

(iv) The commission shall notify the other compacting states of the introduction of such legislation within ten (10) days after its receipt of notice thereof;

(v) The withdrawing state is responsible for all obligations, duties and liabilities incurred through the effective date of withdrawal, including any obligations, the performance of which extend beyond the effective date of withdrawal, except to the extent those obligations may have been released or relinquished by mutual agreement of the commission and the withdrawing state. The commission's approval of products and advertisement prior to the effective date of withdrawal shall continue to be effective and be given full force and effect in the withdrawing state, unless formally rescinded by the withdrawing state in the same manner as provided by the laws of the withdrawing state for the prospective disapproval of products or advertisement previously approved under state law;

(vi) Reinstatement following withdrawal of any compacting state shall occur upon the effective date of the withdrawing state reenacting the compact.

(b) Default shall be as follows:

(i) If the commission determines that any compacting state has at any time defaulted ("defaulting state") in the performance of any of its obligations or responsibilities under this compact, the bylaws or duly promulgated rules or operating procedures, then, after notice and hearing as set forth in the bylaws, all rights, privileges and benefits conferred by this compact on the defaulting state shall be suspended from the effective date of default as fixed by the commission. The grounds for default include, but are not limited to, failure of a compacting state to perform its obligations or responsibilities, and any other grounds designated in commission rules. The commission shall immediately notify the defaulting state in writing of the defaulting state's suspension pending a cure of the default. The commission shall stipulate the conditions and the time period within which the defaulting state must cure its default. If the defaulting state fails to cure the default within the time period specified by the commission, the defaulting state shall be terminated from the compact and all rights, privileges and benefits conferred by this compact shall be terminated from the effective date of termination;

(ii) Product approvals by the commission or product self-certifications, or any advertisement in connection with such product, that are in force on the effective date of termination shall remain in force in the defaulting state in the same manner as if the defaulting state had withdrawn voluntarily pursuant to subsection (a) of this article;

(iii) Reinstatement following termination of any compacting state requires a reenactment of the compact.

(c) Dissolution of the compact shall be as follows:

(i) The compact dissolves effective upon the date of the withdrawal or default of the compacting state which reduces membership in the compact to one (1) compacting state;

(ii) Upon the dissolution of this compact, the compact becomes null and void and shall be of no further force or effect, and the business and affairs of the commission shall be wound up and any surplus funds shall be distributed in accordance with the bylaws.

ARTICLE XV

Severability and construction

(a) The provisions of this compact shall be severable; and if any phrase, clause, sentence or provision is deemed unenforceable, the remaining provisions of the compact shall be enforceable.

(b) The provisions of this compact shall be liberally construed to effectuate its purposes.

ARTICLE XVI

Binding effect of compact and other laws

(a) Other laws:

(i) Nothing herein prevents the enforcement of any other law of a compacting state, except as provided in paragraph (ii) of this subsection;

(ii) For any product approved or certified to the commission, the rules, uniform standards and any other requirements of the commission shall constitute the exclusive provisions applicable to the content, approval and certification of such products. For advertisement that is subject to the commission's authority, any rule, uniform standard or other requirement of the commission which governs the content of the advertisement shall constitute the exclusive provision that a commissioner may apply to the content of the advertisement. Notwithstanding the foregoing, no action taken by the commission shall abrogate or restrict:

(A) The access of any person to state courts;

(B) Remedies available under state law related to breach of contract, tort, or other laws not specifically directed to the content of the product;

(C) State law relating to the construction of insurance contracts; or

(D) The authority of the attorney general of the state, including but not limited to maintaining any actions or proceedings, as authorized by law.

(iii) All insurance products filed with individual states shall be subject to the laws of those states.

(b) Binding effect of this compact:

(i) All lawful actions of the commission, including all rules and operating procedures promulgated by the commission, are binding upon the compacting states;

(ii) All agreements between the commission and the compacting states are binding in accordance with their terms;

(iii) Upon the request of a party to a conflict over the meaning or interpretation of commission actions, and upon a majority vote of the compacting states, the commission may issue advisory opinions regarding the meaning or interpretation in dispute;

(iv) In the event any provision of this compact exceeds the constitutional limits imposed on the legislature of any compacting state, the obligations, duties, powers or jurisdiction sought to be conferred by that provision upon the commission shall be ineffective as to that compacting state, and those obligations, duties, powers or jurisdiction shall remain in the compacting state and shall be exercised by the agency thereof to which those obligations, duties, powers or jurisdiction are delegated by law in effect at the time this compact becomes effective.

CHAPTER 16 - LIFE INSURANCE AND ANNUITY CONTRACTS

ARTICLE 1 - POLICY AND CONTRACT PROVISIONS

26-16-101. Scope and applicability of chapter.

This chapter, except W.S. 26-16-118, 26-16-120 and 26-16-505, applies only to contracts of life insurance and annuities, other than reinsurance, group life insurance and group annuities.

26-16-102. Standard provisions required.

(a) No life insurance policy, other than group and pure endowments with or without return of premiums or of premiums and interest, shall be delivered or issued for delivery in this state unless it contains provisions conforming in substance to each of the applicable provisions specified in W.S. 26-16-103 through 26-16-114. This section does not apply to annuity contracts nor to any provisions of a life insurance policy, or contract supplemental thereto, relating to disability benefits or to additional benefits in case of death by accident or accidental means.

(b) Any of the provisions or portions thereof not applicable to single premium or term policies, to that extent, shall not be incorporated in the policy.

26-16-103. Grace period.

A grace period of thirty (30) days, or, at the insurer's option, of one (1) month of not less than thirty (30) days, or of four (4) weeks in the case of industrial life insurance policies the premiums for which are payable more frequently than monthly, shall be allowed within which the payment of any premium after the first may be made. The policy shall continue in full force during the grace period, which shall be counted from the premium due date specified in the policy. The insurer may impose an interest charge not to exceed six percent (6%) per annum for the number of days of grace elapsing before the payment of the premium, and, whether or not the interest charge is imposed, if a claim arises under the policy during the grace period the amount of any premium due or overdue, together with interest and any deferred installment of the annual premium, may be deducted from the policy proceeds.

26-16-104. Incontestability.

The policy, exclusive of provisions relating to disability benefits or to additional benefits in case of death by accident or accidental means, is incontestable, except for nonpayment of premiums, after it is in force during the insured's lifetime for a period of two (2) years from its date of issue.

26-16-105. Policy and application constitutes entire contract; statements deemed representations.

The policy, or the policy and the application therefor if a copy of the application is endorsed upon or attached to the policy when issued, constitutes the entire contract between the parties and statements contained in the application, in the absence of fraud, are representations and not warranties.

26-16-106. Misstatement of age.

If the age of the insured or of any other person whose age is considered in determining the premium or benefit is misstated, any amount payable or benefit accruing under the policy shall be in an amount as the premium would purchase at the correct age.

26-16-107. Dividends.

(a) In participating policies, beginning not later than the end of the third policy year, the insurer shall annually ascertain and apportion the divisible surplus, if any, that will accrue on the policy anniversary or other dividend date specified in the policy, provided the policy is in force and all premiums to that date are paid. Except as otherwise provided in this section, any dividend payable, at the option of the party entitled to elect the option, shall be either payable in cash or applied to any of the other dividend options provided by the policy. If any other dividend options are provided, the policy shall further state which option is automatically effective if the party does not elect some other option. If the policy specifies a period within which the other dividend option may be elected, the period shall be not less than thirty (30) days following the date on which the dividend is due and payable. The annually apportioned dividend is payable in cash within the meaning of the cash option specified in this subsection even though the policy provides that payment of the dividend is to be deferred for a specified period, provided the period does not exceed six (6) years from the date of apportionment and that interest will be added to the dividend at a specified rate.

(b) Renewable term policies of ten (10) years or less may provide that:

(i) The surplus accrued to the policies shall be determined and apportioned each year after the second policy year and accumulated during each renewal period;

(ii) At the end of the renewal period, on the insured's renewal of the policy, the insurer shall apply the accumulated surplus as an annuity for the next succeeding renewal term in reducing premiums.

(c) In participating industrial life insurance policies, instead of the provision required in subsection (a) of this section, there shall be a provision that beginning not later than the end of the fifth policy year, the policy shall participate annually in the divisible surplus, if any, in the manner set forth in the policy.

(d) This section does not apply to insurance issued in consideration of lapsed or surrendered policies.

26-16-108. Policy loans.

(a) As used in this section:

(i) "Policy" includes certificates issued by a fraternal benefit society and annuity contracts which provide for policy loans;

(ii) "Policyholder" includes the owner of the policy or the person designated to pay premiums as shown on the records of the life insurer;

(iii) "Policy loan" includes any premium loan made under a policy to pay one (1) or more premiums not paid to the life insurer when due;

(iv) "Published monthly average" means:

(A) Moody's Corporate Bond Yield Average-Monthly Average Corporates as published by Moody's Investors Service, Inc. or any successor; or

(B) If the Moody's Corporate Bond Yield Average-Monthly Average Corporates is no longer published, a substantially similar average established by regulation of the commissioner.

(v) "The rate of interest on policy loans" authorized under this section includes the interest rate charged on reinstatement of policy loans for the period during and after any lapse of a policy.

(b) After three (3) full years premiums are paid and after the policy has a cash surrender value and while no premium is in default beyond the grace period, the insurer will advance, on proper assignment or pledge of the policy and on the sole security of the policy, at a specified rate of interest, an amount equal to or at the option of the entitled party less than the policy's loan value. The policy loan value shall be at least equal to the cash surrender value at the end of the then current policy year, provided that the insurer may deduct from the loan value or from the loan proceeds, any existing indebtedness not already deducted in determining the cash surrender value including any interest then accrued but not due, any unpaid balance of the premium for the current policy year and interest on the loan to the end of the current policy year.

(c) The policy may also provide that:

(i) If interest on any indebtedness is not paid when due, it shall be added to the existing indebtedness and shall bear interest at the same rate; and

(ii) If the total indebtedness on the policy, including interest due or accrued, equals or exceeds the amount of the policy loan value, the policy terminates and is void after notice is mailed by the insurer within at least thirty (30) days to the last address of record with the insurer of the insured or other policy owner and of any assignee of record at the insurer's home office.

(d) The policy shall reserve the insurer's right to defer the granting of a loan, other than for the payment of any premium to the insurer, for six (6) months after application. The provision shall also contain a table indicating in writing the loan values each year during the first twenty (20) years of the policy or during the term of the policy, whichever is shorter.

(e) The policy, at the insurer's option, may provide for automatic premium loan.

(f) This section does not apply to:

(i) Term policies;

(ii) Term insurance benefits provided by rider or supplemental policy provisions; or

(iii) Industrial life insurance policies.

(g) Policies issued on or after July 1, 1983 shall provide for policy loan interest rates as follows:

(i) A provision permitting a maximum interest rate of not more than eight percent (8%) per year; or

(ii) A provision permitting an adjustable maximum interest rate established from time to time by the life insurer as authorized by law.

(h) The rate of interest charged on a policy loan made under paragraph (g)(ii) of this section shall not exceed the higher of the published monthly average for the calendar month ending two (2) months prior to the date on which the rate is

determined or the rate used to compute the cash surrender values under the policy during the applicable period plus one percent (1%) per year.

(j) The policy shall contain a provision stating the frequency at which the rate is to be determined for that policy. The maximum rate for each policy shall be determined at regular intervals at least once every twelve (12) months but not more than once every three (3) months. At the intervals specified in the policy:

(i) The rate charged may be increased if the increase determined under subsection (h) of this section increases the rate by one-half percent (1/2%) or more per year; and

(ii) The rate charged shall be reduced if the reduction determined under subsection (h) of this section decreases the rate by one-half percent (1/2%) or more per year.

(k) The life insurer shall:

(i) Notify the policyholder of the initial rate of interest on the loan at the time a cash loan is made;

(ii) Notify the policyholder of the initial rate of interest on a premium loan as soon as reasonably practical after making the initial loan. No notice is required if an additional premium loan is added except as provided in paragraph (iii) of this subsection;

(iii) Provide policyholders having loans reasonable advance notice of any rate increase; and

(iv) Include in notices to policyholders required by this subsection the substance of the pertinent provisions of subsections (g) and (j) of this section.

(m) The loan value of the policy shall be determined in accordance with W.S. 26-16-202(a)(vi). No policy shall terminate in a policy year as the sole result of a change in the interest rate during that policy year. The life insurer shall maintain coverage during that policy year until the time at which it would otherwise have terminated if there had been no interest rate change during that policy year.

(n) The substance of the pertinent provisions of subsections (g) and (j) of this section shall be stated within the policies to which they apply.

(o) No other provision of law shall apply to policy loan interest rates unless made specifically applicable to such rates.

26-16-109. Table of installments required.

In case the policy provides that the proceeds are payable in installments which are determinable at issue of the policy, there shall be a table showing the amounts of the guaranteed installments.

26-16-110. Reinstatement of policies.

(a) Unless the policy has been surrendered for its cash surrender value, or its cash surrender value has been exhausted, or the paid-up term insurance, if any, has expired, the policy will be reinstated at any time within three (3) years, or two (2) years in the case of industrial life insurance policies, from the date of premium default upon:

(i) Written application therefor;

(ii) The production of evidence of insurability satisfactory to the insurer;

(iii) The payment of all premiums in arrears;

(iv) The payment or reinstatement of any other indebtedness to the insurer upon the policy; and

(v) The payment of interest at a rate not exceeding six percent (6%) per annum compounded annually on all payments required for reinstatement.

26-16-111. Time and place of payment of premiums.

The time and place of payment of premiums shall be specified.

26-16-112. Payment of claims.

(a) If the benefits under the policy are payable because of the death of the insured, settlement shall be made upon receipt of proof of death and, at the insurer's option,

surrender of the policy or proof of the interest of the claimant, or both. If an insurer shall specify a particular period prior to the expiration of which settlement shall be made, the period may not exceed the time requirements specified in W.S. 26-15-124. For any private placement policy, settlement may be made in cash or, if allowed under the policy, by distributing assets of the separate account to the claimant with the consent of the policyholder, as long as the fair market value of the assets are independently verified at the time of disbursement by the insurer. In any private placement policy, the obligation of the insurer to settle that portion of the policy attributable to separate account assets is subject to the liquidity of the assets and the insurer shall settle the portion of the policy as and when the assets can be, by their respective terms, either converted to cash, which may be later than the time requirements specified in W.S. 26-15-124, or otherwise dispersible by the insurer.

(b) Benefits shall be paid within the time requirements of W.S. 26-15-124 and shall include interest accrued from the date of death until date of payment. The interest rate shall be not less than the rate of interest payable on death proceeds left on deposit with the insurer. For any private placement policy, the interest shall be computed commencing the latter of sixty (60) days succeeding the date of death of the insured or the date proof of death has been received by the insurer in good order, until the date of payment. In any private placement policy, the obligation of the insurer to pay interest on that portion of the policy attributable to separate account assets may only be computed as and when the assets are, by their respective terms, either converted to cash or otherwise dispersible by the insurer.

(c) For purposes of this section, date of payment shall include the date of the postmark stamped on an envelope properly addressed and postage prepaid, containing the payment.

(d) The provisions of this section requiring the payment of interest shall not apply to variable contracts which provide for insurance or annuity benefits which may vary according to the investment experience of any separate account or accounts maintained by the insurer as to such contract.

(e) As used in this chapter, "private placement policy" is a variable life insurance policy that is:

(i) Issued exclusively to a person who is an accredited investor or a qualified purchaser, as defined in the Securities Act of 1933 or the Investment Company Act of 1940 or in regulations promulgated under either statute; and

(ii) Offered for sale and sold in a transaction that is exempt from registration under the Securities Act of 1933.

26-16-113. Beneficiaries of industrial life insurance policies.

(a) An industrial life insurance policy shall have the name of the beneficiary designated thereon, or in the application or other form if attached to the policy, with a reservation of the right to designate or change the beneficiary after the issuance of the policy, unless the beneficiary is irrevocably designated.

(b) The policy may also provide that:

(i) No designation or change of beneficiary is binding on the insurer until endorsed on the policy by the insurer;

(ii) The insurer may refuse to endorse the name of any proposed beneficiary who does not appear to the insurer to have an insurable interest in the insured's life;

(iii) If the beneficiary designated in the policy does not make a claim under the policy or does not surrender the policy with proof of death within the period stated in the policy, which shall not be less than thirty (30) days after the insured's death, or if the beneficiary is the estate of the insured, or is a minor, or dies before the insured, or is not legally competent to give a valid release, the insurer may make any payment thereunder to the insured's executor or administrator, or to any relative of the insured by blood or legal adoption or connection by marriage, or to any person appearing to the insurer to be equitably entitled thereto because of having been named beneficiary or having incurred expense for the insured's maintenance, medical attention or burial.

(c) The policy may also include a provision similar to that in paragraph (b)(iii) of this section applicable to any other payment due under the policy.

26-16-114. Title on policy.

There shall be a title on the policy briefly describing the policy.

26-16-115. Excluded or restricted coverage under incontestability clause.

A clause in any life insurance policy providing that the policy is incontestable after a specified period precludes only a contest of the policy's validity and does not preclude the assertion at any time of defenses based upon provisions in the policy which exclude or restrict coverage, whether or not the restrictions or exclusions are excepted in the clause.

26-16-116. Annuity and pure endowment contracts; standard provisions.

(a) No annuity or pure endowment contract, other than reversionary, survivorship or group annuities and except as stated in this section, shall be delivered or issued for delivery in this state unless it contains provisions conforming in substance to each of the provisions specified in W.S. 26-16-117. Any of the provisions not applicable to single premium annuities or single premium pure endowment contracts, to that extent, shall not be incorporated in the policy.

(b) This section does not apply to contracts for deferred annuities included in or upon the lives of beneficiaries under life insurance policies.

26-16-117. Annuity and pure endowment contracts; provisions to be contained.

(a) Any annuity or pure endowment contract, other than a reversionary, survivorship or group annuity, shall contain provisions as specified in this section.

(b) There shall be a grace period of one (1) month, but not less than thirty (30) days, within which any stipulated payment to the insurer falling due after the first may be made, subject at the option of the insurer to an interest charge thereon at a rate to be specified in the contract but not exceeding six percent (6%) per annum for the number of days of grace elapsing before the payment. The contract shall continue in full force during the grace period. If a claim arises under the contract because of death prior to expiration of the grace

period before the overdue payment to the insurer or the deferred payments of the current contract year, if any, are made, the amount of the payments, with interest on any overdue payments, may be deducted from any amount payable under the contract in settlement.

(c) If any statements, other than those relating to age, sex and identity, are required as a condition to issuing an annuity or pure endowment contract, and subject to subsection (e) of this section the contract is incontestable after it is in force during the lifetime of the person or of each of the persons as to whom the statements are required, for a period of two (2) years from its date of issue, except for nonpayment of stipulated payments to the insurer. At the insurer's option the contract may also except any provisions relative to benefits in case of disability and any provisions which grant insurance specifically against death by accident or accidental means.

(d) The contract constitutes the entire contract between the parties, or if a copy of the application is endorsed upon or attached to the contract when issued, the contract and the application therefor constitute the entire contract between the parties.

(e) If the age or sex of any person upon whose life the contract is made is misstated, the amount payable or benefits accruing under the contract shall be in an amount as the stipulated payment to the insurer would purchase according to the correct age or sex. If the insurer overpays because of any such misstatement, the amount of overpayment with interest at the rate to be specified in the contract, but not exceeding six percent (6%) per annum, may be charged against the current or next succeeding payment the insurer makes under the contract.

(f) In a participating contract the insurer shall annually ascertain and apportion any divisible surplus accruing on the contract.

(g) The contract may be reinstated at any time within one (1) year from the default in making stipulated payments to the insurer, unless the cash surrender value has been paid. Any overdue stipulated payments and any indebtedness to the insurer on the contract shall be paid or reinstated with interest thereon at a rate to be specified in the contract but not exceeding six percent (6%) per annum payable annually. In applicable cases the insurer may also require evidence of insurability to its satisfaction.

26-16-118. Standard provisions for reversionary annuities.

(a) Except as otherwise provided in this section, no contract for a reversionary annuity shall be delivered or issued for delivery in this state unless it contains in substance:

(i) The provisions specified in W.S. 26-16-117, except that under W.S. 26-16-117 the insurer, at its option, may provide for an equitable reduction of the amount of the annuity payments in settlement of an overdue payment instead of providing for deduction of the payments from an amount payable upon settlement under the contract; and

(ii) A provision that the contract may be reinstated at any time within three (3) years from the date of default in making stipulated payments to the insurer, upon production of evidence of insurability satisfactory to the insurer, and upon condition that all overdue payments and any indebtedness to the insurer because of the contract be paid, or, within the limits permitted by the then cash values of the contract, reinstated with interest as to both payments and indebtedness at a rate to be specified in the contract but not exceeding six percent (6%) per annum compounded annually.

(b) This section does not apply to group annuities or to annuities included in life insurance policies, and any of those provisions not applicable to single premium annuities, to that extent, shall not be incorporated in the policies.

26-16-119. Provisions limiting liability in life insurance policies prohibited; exceptions.

(a) No life insurance policy shall be delivered or issued for delivery in this state if it contains any provision:

(i) Limiting the time within which an action at law or in equity may be commenced on the policy to less than three (3) years after the cause of action has accrued;

(ii) Which excludes or restricts liability for death caused in a certain specified manner or occurring while the insured has a specified status, except that a policy may contain provisions excluding or restricting coverage as specified therein in case of death under any of the following circumstances:

(A) Death as a result, directly or indirectly, of war, declared or undeclared, or of any act or hazard of a war or action;

(B) Death as a result of aviation or any air travel or flight;

(C) Death as a result of a specified hazardous occupation. Service in the military, naval or air forces or in civilian forces auxiliary thereto shall not be a specified hazardous occupation under this subparagraph;

(D) Death while the insured is a resident outside [the] continental United States and Canada; or

(E) Death within two (2) years from the date of issue of the policy as a result of suicide, while sane or insane.

(b) A policy which contains any exclusion or restriction pursuant to subsection (a) of this section shall also provide that in case of death under the circumstances to which the exclusion or restriction applies, the insurer shall pay an amount not less than a reserve determined according to the commissioners' reserve valuation method upon the basis of the mortality table and interest rate specified in the policy for the calculation of nonforfeiture benefits, or if the policy does not provide for such benefits, computed according to a mortality table and interest rate determined by the insurer and specified in the policy, with adjustment for indebtedness or dividend credit.

(c) This section does not apply to group life insurance, disability insurance, reinsurance or annuities, or to any provision in a life insurance policy or contract supplemental thereto relating to disability benefits or to additional benefits in case of death by accident or accidental means.

(d) Nothing in this section prohibits any provision which in the commissioner's opinion is more favorable to the policyholder than a provision permitted by this section.

26-16-120. Prohibited provisions generally in life insurance policies and industrial life insurance policies.

(a) No life insurance policy, other than industrial insurance, shall be issued or delivered in this state, or be issued by any domestic insurer, if it contains any provision:

(i) By which the policy purports to be issued or to take effect more than one (1) year before the original application for the insurance is made, if thereby the insured would rate at an age more than one (1) year younger than his insuring age at date when application is made;

(ii) For any mode of settlement at maturity of the policy of less value than the amount insured under the policy, plus dividend additions, if any, less any indebtedness to the insurer on or secured by the policy and less any premium that, by the terms of the policy, may be deducted. This paragraph does not apply to any nonforfeiture provisions which employ the cash value less indebtedness, if any, to purchase automatic paid-up or extended insurance, nor does it apply to graded death benefits in juvenile policies at ages one (1) to sixteen (16) years.

(b) No industrial life insurance policy shall contain any provision:

(i) By which the insurer may deny liability under the policy for the reason that the insured previously obtained other insurance from the same insurer;

(ii) Giving the insurer the right to declare the policy void because the insured:

(A) Has had any disease or ailment, whether specified or not, or because the insured has received institutional, hospital, medical or surgical treatment or attention, except a provision which gives the insurer the right to declare the policy void if the insured, within two (2) years prior to the issuance of the policy, received institutional, hospital, medical or surgical treatment or attention and if the insured or claimant under the policy fails to show that the condition occasioning that treatment or attention was not of a serious nature or was not material to the risk;

(B) Has been rejected for insurance, unless the right is conditioned upon the insurer showing that knowledge of the rejection would have led to the insurer's refusal to make the contract.

26-16-121. Failure to pay premiums; notification.

When an employer or trustee of a fund established or adopted by an employer, which employer or trustee is deemed the policyholder of the life insurance policy insuring the employer's employees for the benefit of persons other than the employer and where the employer or trustee routinely pays any part of the premium for the policy, if the employer or trustee fails to pay the routinely paid portion of the premium when required under the policy for any reason, the employer or trustee shall notify the employee or beneficiary, electronically or in writing, within thirty (30) days of the failure to pay.

ARTICLE 2 - STANDARD NONFORFEITURE LAW

26-16-201. Short title; policy issue date; valuation manual operative date.

(a) This article is known as the Standard Nonforfeiture Law for Life Insurance.

(b) For the purpose of this article the date of issue of a policy is the date on which the insured's rated age is determined.

(c) For the purpose of this article, "operative date of the valuation manual" means January 1, 2017.

26-16-202. Policy provisions.

(a) No life insurance policy, except as stated in W.S. 26-16-212, shall be delivered or issued for delivery in this state unless it contains provisions conforming in substance to each of the following provisions, or corresponding provisions which the commissioner determines are at least as favorable to the defaulting or surrendering policyholder as are the minimum requirements specified in this subsection and are essentially in compliance with W.S. 26-16-210:

(i) In case of default in any premium payment the insurer will grant, upon proper request not later than sixty (60) 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 the due date, in an amount as is specified in this article. Instead of the stipulated paid-up nonforfeiture benefit, the insurer, upon proper request not later than sixty (60) days after the due date of the premium in

default, may substitute 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;

(ii) Upon surrender of the policy within sixty (60) days after the due date of any premium payment in default after premiums have been paid for at least three (3) full years in the case of ordinary insurance or five (5) full years in the case of industrial insurance, the insurer will pay, instead of any paid-up nonforfeiture benefit, a cash surrender value in an amount as is specified in this article;

(iii) A specified paid-up nonforfeiture benefit is effective as specified in the policy unless the person entitled to make the election elects another available option not later than sixty (60) days after the due date of the premium in default;

(iv) If the policy is 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, the insurer, upon surrender of the policy within thirty (30) days after any policy anniversary, will pay a cash surrender value in an amount as is specified in this article;

(v) 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 of use in calculating cash surrender values and the paid-up nonforfeiture benefits under the policy. All other policies shall contain a statement of the mortality table and interest rate 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 (20) policy years or during the term of the policy, whichever is shorter, those 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 insurer on the policy;

(vi) A statement:

(A) 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;

(B) Explaining 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 insurer on the policy;

(C) That the method of computation has been filed with the insurance supervisory official of the state in which the policy is delivered, if a detailed statement of the method of computation of the values and benefits shown in the policy is not stated in the policy; and

(D) 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 the values and benefits are consecutively shown in the policy.

(b) Any provision or part thereof set forth in paragraphs (a)(i) through (vi) of this section, not applicable by reason of the insurance plan, to the extent inapplicable, may be omitted from the policy.

26-16-203. Cash surrender values.

(a) The insurer may reserve the right to defer the payment of any cash surrender value for a period of six (6) months after demand therefor with surrender of the policy.

(b) Cash surrender value shall be as follows:

(i) Any cash surrender value available under the policy in case of default in a premium payment due on any policy anniversary, whether or not required by W.S. 26-16-202, shall be an amount not less than the excess, if any, of the present value, on the anniversary of the future guaranteed benefits, including any existing paid-up additions, which would have been provided for by the policy if there had been no default, over the sum of:

(A) The then present value of the adjusted premiums as defined in W.S. 26-16-205 through 26-16-209 corresponding to premiums which would have fallen due on and after the anniversary; and

(B) The amount of any indebtedness to the insurer on the policy.

(ii) For any policy issued on or after the operative date of W.S. 26-16-209, which provides supplemental life insurance or annuity benefits at the insured's option and for an identifiable additional premium by rider or supplemental policy provision, the cash surrender value referred to in paragraph (i) of this subsection shall be an amount not less than the sum of the cash surrender value as defined in that paragraph for an otherwise similar policy issued at the same age without the rider or supplemental policy provision and the cash surrender value as defined in that paragraph for a policy which provides only the benefits otherwise provided by the rider or supplemental policy provision;

(iii) For any family policy issued on or after the operative date of W.S. 26-16-209, 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 (71), the cash surrender value referred to in paragraph (i) of this subsection shall be an amount not less than the sum of the cash surrender value as defined in that paragraph for an otherwise similar policy issued at the same age without the term insurance on the life of the spouse and the cash surrender value as defined in the paragraph for a policy which provides only the benefits otherwise provided by the term insurance on the life of the spouse;

(iv) Any cash surrender value available within thirty (30) 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 W.S. 26-16-202(a), shall be an amount not less than the present value, on the anniversary, of the future guaranteed benefits provided for by the policy, including any existing paid-up additions, decreased by any indebtedness to the insurer on the policy.

26-16-204. Paid-up nonforfeiture benefits.

Any paid-up nonforfeiture benefit available under the policy in case of default in a premium payment due on any policy anniversary shall be such that its present value as of the anniversary shall be at least equal to the cash surrender value then provided by the policy or, if none is provided, that cash surrender value which would have been required by this article in the absence of the condition that premiums be paid for at least a specified period.

26-16-205. Section applicability; adjusted premiums.

(a) This section does not apply to policies issued on or after the operative date of W.S. 26-16-209.

(b) Except as provided in W.S. 26-16-207, the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the premiums specified in the policy for each policy year, excluding any extra premiums charged because of impairment or special hazards, that the present value, at the date of issue of the policy, of all the adjusted premiums shall be equal to the sum of:

(i) The then present value of the future guaranteed benefits provided by the policy;

(ii) Two percent (2%) of the amount of insurance, if the insurance is uniform in amount, or of the equivalent uniform amount, as otherwise defined in this article, if the amount of insurance varies with duration of the policy;

(iii) Forty percent (40%) of the adjusted premium for the first policy year;

(iv) Twenty-five percent (25%) 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, except that in applying the percentages specified in paragraph (iii) of this subsection and this paragraph, no adjusted premium is deemed to exceed four percent (4%) of the amount of insurance or uniform amount equivalent thereto.

26-16-206. Varying amount of insurance based on policy duration; uniform equivalent.

(a) 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 W.S. 26-16-205 is the uniform amount of insurance provided by an otherwise similar policy, containing the same endowment 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 as the benefits under the policy.

(b) In the case of a policy providing a varying amount of insurance issued on the life of a child under age ten (10) the equivalent uniform amount may be computed as though the amount of insurance provided by the policy prior to the attainment of age ten (10) were the amount provided by the policy at age ten (10).

26-16-207. Adjustment of premiums for benefits provided by rider or supplemental policy provision.

(a) The adjusted premiums for any policy providing term insurance benefits by rider or supplemental policy provision shall be equal to:

(i) The adjusted premiums for an otherwise similar policy issued at the same age without the term insurance benefits, increased, during the period for which premiums for the term insurance benefits are payable, by;

(ii) The adjusted premiums for the term insurance. Paragraphs (a)(i) and (ii) of this section shall be calculated separately and as specified in W.S. 26-16-205 and 26-16-206, except that for the purposes of W.S. 26-16-205(b)(ii), (iii) and (iv), the amount of insurance or equivalent uniform amount of insurance used in the calculation of the adjusted premiums referred to in this paragraph 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 paragraph (a)(i) of this section.

26-16-208. Section applicability; calculation of certain adjusted premiums.

(a) This section does not apply to ordinary policies issued on or after the operative date of W.S. 26-16-209. All adjusted premiums and present values referred to in this article, for all policies of ordinary insurance, shall be

calculated on the basis of the commissioners' 1958 standard ordinary mortality table, except 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 (6) years younger than the insured's actual age.

(b) Calculations for all policies of industrial insurance shall be made on the basis of the commissioners' 1961 standard industrial mortality table.

(c) All calculations shall be made on the basis of the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits. The rate of interest shall not exceed three and one-half percent (3 1/2%) per annum, except that a rate of interest not exceeding four percent (4%) per annum may be used for policies issued on or after July 1, 1975 and prior to May 20, 1981 and a rate of interest not exceeding five and one-half percent (5 1/2%) per annum may be used for policies issued on or after May 20, 1981.

(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' 1958 extended term insurance table in the case of ordinary insurance, and the commissioners' 1961 industrial extended term insurance table in the case of industrial policies.

(e) For insurance issued on a substandard basis, the calculation of any adjusted premiums and present values may be based on any mortality table the insurer specifies and the commissioner approves.

26-16-209. Section applicability; premium adjustment for any policy; annual calculation; exception.

(a) This section applies to policies issued on or after the operative date in subsection (n) of this section.

(b) Except as provided in subsection (h) of this section, the adjusted premiums for any policy shall be calculated on an annual basis and shall be the uniform percentage of the premiums specified in the policy for each policy year, excluding:

(i) Amounts payable as extra premiums to cover impairments or special hazards; and

(ii) 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 by the policy;

(B) One percent (1%) 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 (10) policy years; and

(C) One hundred twenty-five percent (125%) of the nonforfeiture net level premium as otherwise defined in this section. In applying this percentage, no nonforfeiture net level premium is deemed to exceed four percent (4%) 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 (10) policy years.

(D) Repealed By Laws 2011, Ch. 176, § 2.

(c) The nonforfeiture net level premium shall be equal to the present value, at the date of issue of the policy, of the guaranteed benefits provided by the policy divided by the present value, at the date of issue of the policy, of an annuity of one (1) per annum payable on the date of issue of the policy and on each policy anniversary on which a premium falls due.

(d) For 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 policy issue. 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.

(e) Except as provided in subsection (h) of this section the recalculated future adjusted premiums for any such policy

shall be the uniform percentage of the 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 the future adjusted premiums shall be equal to the excess of: 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 the then cash surrender value, if any, or present value of any paid-up nonforfeiture benefit under the policy.

(f) The additional expense allowance, at the time of the change to the newly defined benefits or premiums, shall be the sum of:

(i) One percent (1%) of the excess, if positive, of the average amount of insurance at the beginning of each of the first ten (10) policy years after the change over the average amount of insurance prior to the change at the beginning of each of the first ten (10) policy years after the time of the most recent previous change, or, if there has been no previous change, the date of issue of the policy; and

(ii) One hundred twenty-five percent (125%) of the increase, if positive, in the nonforfeiture net level premium.

(g) The recalculated nonforfeiture net level premium shall be equal to the result obtained by dividing (i) by (ii) where:

(i) Equals the sum of:

(A) The nonforfeiture net level premium applicable prior to the change times the present value of an annuity of one (1) per annum payable on each anniversary of the policy on or after 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; and

(ii) Equals the present value of an annuity of one (1) per annum payable on each policy anniversary on or after the date of change on which a premium falls due.

(h) Notwithstanding any provision of this section, for 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 may be calculated as if the policy were issued to provide the higher uniform amounts of insurance on the standard basis.

(j) All adjusted premiums and present values referred to in this article shall be calculated for all policies of ordinary insurance on the basis of the commissioners' 1980 standard ordinary mortality table or, at the election of the company for any one (1) or more specified life insurance plans, the commissioners' 1980 standard ordinary mortality table with ten-year select mortality factors; for all industrial insurance policies on the basis of the commissioners' 1961 standard industrial mortality table; and for all policies issued in a particular calendar year 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, except that:

(i) At the insurer's option, 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 subsection, for policies issued in the immediately preceding calendar year;

(ii) Under any paid-up nonforfeiture benefit, including any paid-up dividend additions, any cash surrender value available, whether or not required by W.S. 26-16-202(a), shall be calculated on the basis of the mortality table and rate of interest used in determining the amount of the paid-up nonforfeiture benefit and paid-up dividend additions, if any;

(iii) 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 not lower than that specified in the policy for calculating cash surrender values;

(iv) 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 shall not be 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;

(v) For insurance issued on a substandard basis, the calculation of the adjusted premiums and present values may be based on appropriate modifications of the tables specified in this subsection;

(vi) For policies issued prior to the operative date of the valuation manual, any commissioners' standard ordinary mortality tables the NAIC adopts after 1980, that are approved by regulation the commissioner promulgates, 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;

(vii) For policies issued on or after the operative date of the valuation manual, the valuation manual shall provide the commissioners' standard mortality table for use in determining the minimum nonforfeiture standard that 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. If the commissioner approves by regulation any commissioners' standard ordinary mortality table adopted by the NAIC for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual then that minimum nonforfeiture standard supersedes the minimum nonforfeiture standard provided by the valuation manual;

(viii) For policies issued prior to the operative date of the valuation manual, any commissioners' standard industrial mortality tables the NAIC adopts after 1980, that are approved by regulation the commissioner promulgates, 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;

(ix) For policies issued on or after the operative date of the valuation manual, the valuation manual shall provide the commissioners' standard mortality table for use in determining the minimum nonforfeiture standard that may be

substituted for the commissioners' 1961 standard industrial mortality table or the commissioners' 1961 industrial extended term insurance table. If the commissioner approves by regulation any commissioners' standard industrial mortality table adopted by the NAIC for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual then that minimum nonforfeiture standard supersedes the minimum nonforfeiture standard provided by the valuation manual.

(k) The nonforfeiture interest rate is defined as follows:

(i) For policies issued prior to the operative date of the valuation manual, the nonforfeiture interest rate per annum for any policy issued in a particular calendar year is equal to one hundred twenty-five percent (125%) of the calendar year statutory valuation interest rate for such policy as defined in the standard valuation law rounded to the nearer one-fourth percent (1/4%), provided the nonforfeiture interest rate shall not be less than four percent (4%);

(ii) For policies issued on or after the operative date of the valuation manual, the nonforfeiture interest rate per annum for any policy issued in a particular calendar year shall be provided by the valuation manual.

(m) Notwithstanding any other provision in this code to the contrary, any refiling or 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.

(n) After the effective date of this section, any insurer may file with the commissioner a written notice of its election to comply with this section after a specified date before January 1, 1989, and the date specified is the operative date of this section for the insurer, except that if an insurer does not make the election, the operative date of this section for the insurer is January 1, 1989. Before that date the election may be made on a product-by-product basis.

26-16-210. Determination of specified life insurance plan premiums and benefits.

(a) For any life insurance plan which provides for future premium determination, the amounts of which are to be determined

by the insurer based on the then estimates of future experience, or for any life insurance plan which is of such a nature that minimum values cannot be determined by the methods described in W.S. 26-16-202 through 26-16-209, the commissioner shall be satisfied that:

(i) The benefits provided under the plan are substantially as favorable to policyholders and insureds as the minimum benefits otherwise required by W.S. 26-16-202 through 26-16-209;

(ii) The benefits and the pattern of premiums of that plan are not such as to mislead prospective policyholders or insureds.

(b) The cash surrender values and paid-up nonforfeiture benefits provided by the plan shall not be less than the minimum values and benefits required for the plan computed by a method consistent with the principles of this article for life insurance, as determined by regulations the commissioner promulgates.

(c)(i) This subsection, in addition to all other applicable subsections of this section, applies to all policies issued on or after January 1, 1986. 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 (.2%) 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 (10) policy years, from the sum of (A) the greater of zero and the basic cash value as specified in this subsection and (B) the present value of any existing paid-up additions less the amount of any indebtedness to the insurer under the policy;

(ii) The basic cash value shall be 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 insurer, if there had been no default, less the then present value of the nonforfeiture factors, as specified in paragraph (iii) of this subsection, 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 W.S. 26-16-203 or 26-16-207, whichever

is applicable, shall be the same as are the effects specified in W.S. 26-16-203 or 26-16-207, whichever is applicable on the cash surrender values defined in that subsection;

(iii) The nonforfeiture factor for each policy year shall be an amount equal to a percentage of the adjusted premium for the policy year, as defined in W.S. 26-16-205, 26-16-206 and 26-16-207 or in W.S. 26-16-209, whichever is applicable. Except as is required by subparagraph (A) of this paragraph, such percentage:

(A) Must be the same percentage for each policy year between the second policy anniversary and the later of (1) the fifth policy anniversary and (2) 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 (.2%) 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 (10) policy years; and

(B) Must be such that no percentage after the later of the two (2) policy anniversaries specified in subparagraph (A) of this paragraph may apply to fewer than five (5) consecutive policy years.

(iv) No basic cash value may be less than the value which would be obtained if the adjusted premiums for the policy, as defined in W.S. 26-16-205, 26-16-206 and 26-16-207 or in W.S. 26-16-209, whichever is applicable, were substituted for the nonforfeiture factors in the calculation of the basic cash value;

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

(vi) 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 W.S. 26-16-202, 26-16-203, 26-16-204, 26-16-209, and 26-16-211. 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 paragraphs (i) through (vi) of this subsection shall conform with the principals of this section.

26-16-211. Calculating cash surrender and paid-up nonforfeiture benefits for premium default other than on policy anniversary.

(a) Any cash surrender value and any paid-up nonforfeiture benefit, available under the policy in case 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 W.S. 26-16-203(b) through 26-16-209 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 not be less than the amounts used to provide the additions. Notwithstanding W.S. 26-16-203(b), the following additional benefits payable shall be disregarded in ascertaining cash surrender values and nonforfeiture benefits required by this article and are not required to be included in any paid-up nonforfeiture benefits:

(i) In case of death or dismemberment by accident or accidental means;

(ii) In case of total and permanent disability;

(iii) As reversionary annuity or deferred reversionary annuity benefits;

(iv) As term insurance benefits provided by a rider or supplemental policy provision to which, if issued as a separate policy, this section would not apply;

(v) As term insurance on the life of a child provided in a policy on the life of a parent of the child, if the term insurance expires before the child's age is twenty-six (26), is uniform in amount after the child's age is one (1) and is not paid-up because of the death of a parent of the child; and

(vi) As other policy benefits additional to life insurance and endowment benefits, and premiums for all the additional benefits.

26-16-212. Applicability of article.

(a) This article does not apply to any:

(i) Reinsurance;

(ii) Group insurance;

(iii) Pure endowment;

(iv) Annuity or reversionary annuity contract;

(v) Term policy of uniform amount which provides no guaranteed nonforfeiture or endowment benefits, or renewal thereof, of twenty (20) years or less expiring before age seventy-one (71), for which uniform premiums are payable during the entire term of the policy;

(vi) Term policy of decreasing amount which provides no guaranteed nonforfeiture or endowment benefits and on which each adjusted premium, calculated as specified in W.S. 26-16-205 through 26-16-209, is less than the adjusted premium so calculated, on a term policy of uniform amount, or renewal thereof, which provides no guaranteed nonforfeiture or endowment benefits, issued at the same age, for the same initial amount of insurance, and for a term of twenty (20) years or less expiring before age seventy-one (71), for which uniform premiums are payable during the entire term of the policy;

(vii) Policy which provides no guaranteed nonforfeiture or endowment benefits and for which no cash surrender value or present value of paid-up nonforfeiture benefit at the beginning of the policy year and calculated as specified in W.S. 26-16-203(b) through 26-16-209, exceed two and one-half percent (2 1/2%) of the amount of insurance at the beginning of the policy year. For purposes of paragraph (vi) of this subsection and this paragraph, the age at expiration of a joint term life insurance policy is the age at expiration of the oldest life; or

(viii) Policy which is delivered outside this state through an agent or other representative of the insurer issuing the policy.

ARTICLE 3 - NONFORFEITURE BENEFITS ON OLD POLICIES

26-16-301. Nonforfeiture benefits on old policies.

(a) In the case of policies referred to in W.S. 26-16-102 and issued prior to the operative date of article 2 of this chapter, there shall be a provision which, in case of default in premium payments after premiums are paid for three (3) years, shall secure to the policy owner, as a nonforfeiture benefit, a stipulated form of insurance, the net value of which is at least equal to the minimum life insurance reserve at the date of the default on the policy and on any dividend addition thereto, as required by article 2 of chapter 6 of this code, less a sum not more than two and one-half percent (2 1/2%) of the amount insured by the policy and of any existing dividend additions thereto, and less any existing indebtedness to the insurer on or secured by the policy.

(b) The net value specified in subsection (a) of this section shall be determined on the basis of a mortality table and rate of interest stated in the policy and acceptable for the valuation of the policy pursuant to the standard valuation law, except that if the mortality table is a more modern table than the American experience table of mortality, a mortality rate not more than one hundred thirty percent (130%) of the mortality rate according to the more modern table may be used in calculating any extended insurance, with accompanying pure endowment, if any, offered as a nonforfeiture benefit. If the mortality table used as the basis of determining the net value is the commissioners' 1958 standard ordinary mortality table, the mortality rates to be assumed in calculating any extended insurance, with accompanying pure endowment, if any, shall not be more than those shown in the commissioners' 1958 extended term insurance table.

(c) The provision specified in subsection (a) of this section shall:

(i) Stipulate that the policy may be surrendered to the insurer at its home office within one (1) month from date of default, for a specified cash value equal to the sum which would otherwise be available for the purchase of insurance as specified in subsection (a) of this section, and may stipulate that the insurer may defer payment for not more than six (6) months after the application therefor is made;

(ii) Contain a table showing the options available under the policy each year upon default in premium payments during the first twenty (20) years of the policy, or during the term of the policy whichever is shorter;

(iii) Not be required in term insurances of twenty (20) years or less or in industrial life insurance policies.

ARTICLE 4 - STANDARD NONFORFEITURE LAW FOR INDIVIDUAL DEFERRED ANNUITIES

26-16-401. Short title.

This article is known as the "Standard Nonforfeiture Law For Individual Deferred Annuities".

26-16-402. Applicability of article.

(a) This article does not apply to any:

(i) Reinsurance;

(ii) Group annuity purchased under a retirement plan or plan of deferred compensation established or maintained by an employer, an employee organization, or both, other than a plan providing individual retirement accounts or annuities under Section 408 of the Internal Revenue Code;

(iii) Premium deposit fund;

(iv) Variable annuity;

(v) Investment annuity;

(vi) Immediate annuity;

(vii) Deferred annuity contract after annuity payments have commenced;

(viii) Reversionary annuity; or

(ix) Contract which is delivered outside this state through an agent or other representative of the company issuing the contract.

26-16-403. Contract provisions.

(a) In the case of contracts issued on or after the operative date of this article as defined in W.S. 26-16-411, no annuity contract, except as stated in W.S. 26-16-402, shall be delivered or issued for delivery in this state unless it contains in substance the following provisions, or corresponding provisions which the commissioner determines are at least as favorable to the contract holder, upon cessation of payment of considerations under the contract or upon the written request of the contract owner:

(i) The company shall grant a paid-up annuity benefit on a plan stipulated in the contract of a value as is specified in W.S. 26-16-405 through 26-16-409;

(ii) If a contract provides for a lump sum settlement at maturity, or at any other time, that upon surrender of the contract at or prior to the commencement of any annuity payments, the company shall pay instead of any paid-up annuity benefit a cash surrender benefit in an amount as is specified in W.S. 26-16-405, 26-16-406, 26-16-408 and 26-16-409, provided the company may reserve the right to defer the payment of the cash surrender benefit for a period not to exceed six (6) months after demand therefore with surrender of the contract and after making written request and receiving the written approval of the commissioner. The request shall address the necessity and equitability to all policyholders of the deferral;

(iii) A statement of the mortality table and interest rates used in calculating any minimum paid-up annuity, cash surrender or death benefits that are guaranteed under the contract, together with sufficient information to determine the amounts of those benefits;

(iv) A statement that any paid-up annuity, cash surrender or death benefits available under the contract are not less than the minimum benefits required by any statute of the state in which the contract is delivered and an explanation of the manner in which the benefits are altered by the existence of any additional amounts the company credits to the contract, any indebtedness to the company on the contract or any prior withdrawals from or partial surrenders of the contract;

(v) Any contract which does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount prior to the commencement of any annuity payments shall include a statement

in a prominent place in the contract that those benefits are not provided;

(vi) Notwithstanding the requirements of this section, any deferred annuity contract may provide that if no considerations are received under a contract for a period of two (2) full years and the portion of the paid-up annuity benefit at maturity on the plan stipulated in the contract arising from considerations paid prior to the period would be less than twenty dollars ($20.00) monthly, the company, at its option, may terminate the contract by payment in cash of the then present value of the portion of the paid-up annuity benefit, calculated on the basis of the mortality table and interest rate specified in the contract for determining the paid-up annuity benefit, and by that payment is relieved of any further obligation under the contract.

26-16-404. Minimum nonforfeiture amounts upon which certain minimum values are to be based.

(a) The minimum values as specified in W.S. 26-16-405 through 26-16-409 of any paid-up annuity, cash surrender or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts as defined in subsections (b) through (f) of this section.

(b) The minimum nonforfeiture amounts shall be governed by the following:

(i) The minimum nonforfeiture amount at any time at or prior to the commencement of any annuity payments shall be equal to an accumulation up to that time at rates of interest as provided in subsection (e) of this section of the net considerations paid prior to that time decreased by the sum of any prior withdrawals from or partial surrenders of the contract accumulated at rates of interest provided in subsection (e) of this section, an annual contract charge of fifty dollars ($50.00), accumulated at rates of interest as provided in subsection (e) of this section, and any premium tax paid by the company for the contract, accumulated at rates of interest as provided in subsection (e) of this section, and the amount of any indebtedness to the company on the contract, including interest due and accrued. The net considerations for a given contract year used to define the minimum nonforfeiture amount shall be an amount equal to eighty-seven and one-half percent (87 ½%) of the gross considerations credited to the contract during that contract year;

(ii) For contracts issued on or after July 1, 2003, and before July 1, 2007, the provisions of paragraph (i) of this subsection apply, except that the minimum nonforfeiture amount shall be based upon a rate of interest of one and one-half percent (1.5%) per annum.

(c) Repealed By Laws 2006, Chapter 6, § 2.

(d) Repealed By Laws 2006, Chapter 6, § 2.

(e) The interest rate used in determining minimum nonforfeiture amounts shall be an annual rate of interest determined as follows:

(i) The lesser of three percent (3%) per annum and the following, which shall be specified in the contract if the interest rate will be reset:

(A) The five (5) year constant maturity treasury rate reported by the federal reserve as of a date, or average over a period, rounded to the nearest one-twentieth of one percent (.05%), specified in the contract no longer than fifteen (15) months prior to the contract issue date or redetermination date under paragraph (iii) of this subsection;

(B) Reduced by one hundred twenty-five (125) basis points.

(ii) Notwithstanding paragraph (i) of this subsection, the resulting interest rate shall not be less than fifteen one-hundredths of one percent (0.15%);

(iii) The interest rate shall apply for an initial period and may be redetermined for additional periods. The redetermination date, basis and period, if any, shall be stated in the contract. The basis is the date or average over a specified period that produces the value of the five (5) year constant maturity treasury rate to be used at each redetermination date.

(f) During the period or term that a contract provides substantive participation in an equity indexed benefit, it may increase the reduction described in subparagraph (e)(i)(B) of this section by up to an additional one hundred (100) basis points to reflect the value of the equity index benefit. The present value at the contract issue date, and at each

redetermination date thereafter, of the additional reduction shall not exceed the market value of the benefit. The commissioner may require a demonstration that the present value of the additional reduction does not exceed the market value of the benefit. Lacking such a demonstration that is acceptable to the commissioner, the commissioner may disallow or limit the additional reduction.

(g) The commissioner may adopt rules to implement the provisions of subsection (f) of this section and to provide for further adjustments to the calculation of minimum nonforfeiture amounts for contracts that provide substantive participation in an equity index benefit and for other contracts that the commissioner determines are justified.

26-16-405. Present value of paid-up annuity benefits.

Any paid-up annuity benefit available under a contract shall be such that its present value on the date annuity payments are to commence is at least equal to the minimum nonforfeiture amount on that date. The present value shall be computed using the mortality table and the interest rate specified in the contract for determining the minimum paid-up annuity benefits guaranteed in the contract.

26-16-406. Calculating cash surrender benefits available prior to contract maturity.

(a) For contracts which provide cash surrender benefits, cash surrender benefits available prior to maturity shall not be less than an amount determined as follows:

(i) Determine the present value as of the date of surrender of that portion of the maturity value of the paid-up annuity benefit which would be provided under the contract at maturity, arising from considerations paid prior to the time of cash surrender;

(ii) The amount determined in paragraph (i) of this subsection shall be reduced by the amount appropriate to reflect any prior withdrawals from or partial surrenders of the contract with the present value being calculated on the basis of an interest rate not more than one percent (1%) higher than the interest rate specified in the contract for accumulating the net considerations to determine the maturity value;

(iii) The amount determined in paragraph (ii) of this subsection shall be decreased by the amount of any indebtedness to the company on the contract, including interest due and accrued; and

(iv) The amount determined in paragraph (iii) of this subsection shall be increased by any existing additional amounts credited by the company to the contract. In no case shall any cash surrender benefit be less than the minimum nonforfeiture amount at that time. The death benefit under the contracts shall be at least equal to the cash surrender benefit.

26-16-407. Minimum paid-up annuity benefit available as a nonforfeiture option.

For contracts which do not provide cash surrender benefits, the present value of any paid-up annuity benefit available as a nonforfeiture option at any time prior to maturity shall not be less than the present value of that portion of the maturity value of the paid-up annuity benefit provided under the contract arising from considerations paid prior to the time the contract is surrendered in exchange for, or changed to, a deferred paid-up annuity, with the present value being calculated for the period prior to the maturity date on the basis of the interest rate specified in the contract for accumulating the net considerations to determine the maturity value, and increased by any existing additional amounts credited by the company to the contract. For contracts which do not provide any death benefits prior to the commencement of any annuity payments, the present values shall be calculated on the basis of the interest rate and the mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit. The present value of a paid-up annuity benefit shall not be less than the minimum nonforfeiture amount at that time.

26-16-408. Annuity contract optional maturity dates.

For the purpose of determining the benefits calculated under W.S. 26-16-406 and 26-16-407 in the case of annuity contracts under which an election may be made to have annuity payments commence at optional maturity dates, the maturity date is the latest date for which election is permitted by the contract, but not later than the anniversary of the contract immediately following the annuitant's seventieth birthday or the tenth anniversary of the contract, whichever is later.

26-16-409. Calculating benefits under contracts with fixed schedule considerations.

Any paid-up annuity, cash surrender or death benefits available at any time, other than on the contract anniversary, under any contract with fixed scheduled considerations, shall be calculated with allowance for the lapse of time and the payment of any scheduled considerations beyond the beginning of the contract year in which cessation of payment of considerations under the contract occurs.

26-16-410. Calculating minimum annuity and life insurance nonforfeiture benefits when included by rider or supplemental contract provision.

For any contract which provides therein, by rider or supplemental contract provision, both annuity benefits and life insurance benefits that exceed the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits shall be equal to the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion computed as if each portion were a separate contract. Notwithstanding W.S. 26-16-405 through 26-16-409 additional benefits payable in case of total and permanent disability, as reversionary annuity or deferred reversionary annuity benefits or as other policy benefits additional to life insurance, endowment and annuity benefits, and considerations for all those additional benefits, shall be disregarded in ascertaining the minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits required by this article. The inclusion of the additional benefits is not required in any paid-up benefits, unless the additional benefits separately would require minimum nonforfeiture amounts, paid-up annuity, cash surrender and death benefits.

26-16-411. Operative date of article.

(a) After May 20, 1981, any company may file with the commissioner a written notice of its election to comply with this article after a specified date before May 20, 1983. After filing the notice, then upon the specified date, which is the operative date of this article for that company, this article is operative with respect to annuity contracts thereafter issued by that company. If a company does not make an election, the operative date of this article for that company is May 20, 1983.

(b) Beginning July 1, 2006, any company may elect to apply the provisions of this article on a contract form by contract form basis to all annuity contracts thereafter issued.

(c) On or after July 1, 2007, this article is operative with respect to all annuity contracts thereafter issued.

ARTICLE 5 - MISCELLANEOUS PROVISIONS

26-16-501. Incontestability and limitation of liability after reinstatement.

(a) A reinstated life insurance policy or annuity contract may be contested because of fraud or misrepresentation of facts material to the reinstatement only for the same period following reinstatement and with the same conditions and exceptions as the policy provides for contestability after original issuance.

(b) If any life insurance policy or annuity contract is reinstated, the reinstated policy or contract may exclude or restrict liability to the same extent that the liability could have been or was excluded or restricted when the policy or contract was originally issued. The exclusion or restriction is effective from the date of reinstatement.

26-16-502. Allocation to separate accounts to provide for life insurance or annuities; regulation of variable contracts.

(a) A domestic life insurer may establish one (1) or more separate accounts and may allocate to those accounts amounts, including without limitation proceeds applied under optional modes of settlement or under dividend options, to provide for life insurance or annuities and benefits incidental thereto, payable in fixed or variable amounts or both, subject to the following:

(i) The income and any gains and losses from assets allocated to a separate account shall be credited to or charged against the account, without regard to the insurer's other income, gains or losses;

(ii) Except as may be provided with respect to reserves for guaranteed benefits and funds referred to in paragraph (iii) of this subsection, amounts allocated to any separate account and accumulations thereon may be invested and reinvested without regard to any requirements or limitations prescribed by the laws of this state governing the investments

of life insurance companies, and the investments in the separate accounts shall not be considered in applying the investment limitations otherwise applicable to the insurer's investments;

(iii) Except with the commissioner's approval and under conditions he prescribes as to investments and other matters, which conditions shall recognize the guaranteed nature of the benefits provided, reserves for benefits guaranteed as to dollar amount and duration and funds guaranteed as to principal amount or stated rate of interest shall not be maintained in a separate account;

(iv) Unless the commissioner otherwise approves:

(A) Assets allocated to a separate account shall be valued at their market value on the date of valuation, or if there is no readily available market, then as provided under the terms of the contract or the rules or other written agreement applicable to the separate account;

(B) The portion, if any, of the assets of the separate account which are equal to the insurer's reserve liability with regard to the guaranteed benefits and funds referred to in paragraph (iii) of this subsection shall be valued in accordance with the rules otherwise applicable to the insurer's assets.

(v) The insurer shall own amounts allocated to a separate account under this section and shall not be nor hold itself out to be a trustee with respect to those amounts;

(vi) If and to the extent provided under the applicable contracts, that portion of the assets of any separate account equal to the reserves and other contract liabilities with respect to the account are not chargeable with liabilities arising out of any other business the insurer conducts;

(vii) No insurer shall sell, exchange or otherwise transfer its assets between any of its separate accounts, or between any other investment account and one (1) or more of its separate accounts unless:

(A) In case of a transfer into a separate account, the transfer is made solely to establish the account or to support the operation of the contracts with respect to the separate account to which the transfer is made;

(B) The transfer, whether into or from a separate account, is made by a transfer of cash or by a transfer of securities having a readily determinable market value; and

(C) The commissioner approves the transfer of securities, provided the commissioner may approve other transfers among the accounts if, in his opinion, the transfers are not inequitable.

(viii) To the extent deemed necessary to comply with any applicable federal or state laws, the insurer, with respect to any separate account, including without limitation any separate account which is a management investment company or a unit investment trust, may provide for persons having an interest therein appropriate voting and other rights and special procedures for the conduct of the business of the account, including special rights and procedures relating to investment policy, investment advisory services, selection of independent public accountants and the selection of a committee, the members of which need not be otherwise affiliated with the insurer, to manage the business of the account.

(b) Any contract providing benefits payable in variable amounts delivered or issued for delivery in this state shall contain a statement of the essential features of the procedures the insurer is to follow in determining the dollar amount of the variable benefits. The contract under which the benefits vary to reflect investment experience, including a group contract and any certificate in evidence of variable benefits issued thereunder, shall state that the dollar amount will vary and shall contain on its first page a statement to the effect that the benefits thereunder are on a variable basis.

(c) No insurer shall deliver or issue for delivery within this state variable contracts unless it is licensed to do a life insurance or annuity business in this state, and the commissioner is satisfied that its condition or method of operation in connection with the issuance of the contracts will not render its operation hazardous to the public or its policyholders in this state. In this connection, the commissioner shall consider among other things:

(i) The insurer's history and financial condition;

(ii) The character, responsibility and fitness of the insurer's officers and directors; and

(iii) The law and regulation under which the insurer is authorized in the state of domicile to issue variable contracts. The state of entry of an alien insurer is its place of domicile for this purpose. If the insurer is a subsidiary of an admitted life insurer, or affiliated with that insurer through common management or ownership, it may be deemed by the commissioner to have met the provisions of this subsection if either it or the parent or the affiliated insurer meets the requirements thereof.

(d) Notwithstanding any other provision of law, the commissioner has sole authority to:

(i) Regulate the issuance and sale of variable contracts; and

(ii) Issue reasonable rules and regulations appropriate to carry out the purposes of this section.

(e) Except for W.S. 26-16-117(a), (b) and (g), 26-16-118 and article 2 of this chapter in the case of a variable annuity contract and W.S. 26-16-103, 26-16-108 through 26-16-110, 26-16-201 through 26-16-212 and 26-17-111 in the case of a variable life insurance contract and except as otherwise provided in this section, all pertinent provisions of this code apply to separate accounts and contracts relating thereto. Any individual variable life insurance contract delivered or issued for delivery in this state shall contain grace, reinstatement and nonforfeiture provisions appropriate to the contract. Any individual variable annuity contract delivered or issued for delivery in this state shall contain grace and reinstatement provisions appropriate to the contract. Any group variable life insurance contract delivered or issued for delivery in this state shall contain a grace provision appropriate to the contract. The reserve liability for variable contracts shall be established in accordance with actuarial procedures that recognize the variable nature of the benefits provided and any mortality guarantees.

26-16-503. Insurer issuing participating and nonparticipating policies; records.

(a) Any life insurer issuing both participating and nonparticipating policies shall maintain any accounting records necessary for it to determine dividends to participating policyholders on an equitable basis.

(b) In the accounting records the insurer shall make a reasonable allocation as between participating and nonparticipating policies of the expenses of the general operations or functions as are jointly shared. Any allocation of expense as between categories shall be made upon a reasonable basis, to the end that each category shall bear a just portion of joint expense involved in the administration of the business of that category.

(c) No policy shall provide for and no life insurer or representative shall knowingly offer or promise payment, credit, or distribution of participating "dividends", "earnings", "profits" or "savings", by whatever name called, to participating policies out of the profits, earnings or savings on nonparticipating policies. This provision does not restrict the generality of W.S. 26-13-110.

26-16-504. Policy plans prohibited.

(a) No life insurer shall deliver or issue for delivery in this state:

(i) As part of or in combination with any life insurance, endowment or annuity contract, any agreement or plan, additional to the rights, dividends and benefits arising out of the contract, which provides for the accumulation of profits over a period of years and for payment of any of the accumulated profits only to members or policyholders of a designated group or class who continue as members or policyholders until the end of a specified or ascertainable period of years;

(ii) Any policy purporting to be "registered" or otherwise specially recorded with any agency of the state of Wyoming, or of any other state, or with any bank, trust company, escrow company or other institution other than the insurer or purporting that any reserves, assets or deposits are held for the special benefit or protection of the holder of the policy by or through the agency or institution;

(iii) Any policy or contract under which any part of the premium or of funds or values arising from the policy or contract or from investment of reserves, mortality savings, lapses or surrenders, in excess of the normal reserves or amounts required to pay death, endowment and nonforfeiture benefits in amounts as specified in or pursuant to the policy or contract, are on a basis not involving insurance or life contingency features to be placed in special funds, segregated

accounts or specially designated places or to be invested in specially designated investments or types thereof, and the funds or earnings thereon to be divided among the holders of the policies or contracts, or their beneficiaries or assignees;

(iv) Any policy providing for the segregation of policyholders into mathematical groups and providing benefits for a surviving policyholder arising out of the death of another policyholder of the group, or under any other similar plan;

(v) Any policy providing benefits or values for surviving or continuing policyholders contingent upon the lapse or termination, for any reason, of the policies of other policyholders;

(vi) Any policy containing or referring to:

(A) Investment returns or profit-sharing, other than as a participation in the insurer's divisible surplus under a regular participation provision as provided for in W.S. 26-16-107;

(B) Special treatment in the determination of any dividend that may be paid as to the policy;

(C) Premiums as "deposits";

(D) Policyholder interest or returns to those of stockholders;

(E) The policyholder as a member of a select group who is entitled to extra benefits or extra dividends not available to policyholders generally;

(F) Any label, name or description of the policy as a "founders", "charter" or "coupon" policy, or name of similar connotation.

(vii) Any policy which in addition to basic life insurance benefits provides for or is combined with a series of coupons, or with a passbook or other device generally associated with securities investments, or with savings, banking or investment institutions.

(b) This section does not prohibit the provision, payment, allowance or apportionment of dividends or "savings" under regular participating forms of policies or contracts.

26-16-505. Unclaimed life insurance benefits.

(a) An insurer shall perform a comparison of its insureds' policies and retained asset accounts against a death master file on at least a semi-annual basis by using the full death master file once and thereafter using the death master file update files for future comparisons in order to identify potential matches of its insureds.

(b) Not later than ninety (90) days after a death master file match an insurer shall:

(i) Complete and document a good faith effort to confirm the death of the insured or retained asset account holder against other available records and information; and

(ii) Determine whether benefits are due in accordance with the applicable policy. If benefits are due in accordance with the applicable policy the insurer shall complete and document good faith efforts to locate the beneficiary. The insurer shall also provide the appropriate claims forms or instructions to the beneficiary to make a claim including the need to provide an official death certificate, if applicable under the policy.

(c) With respect to group life insurance, an insurer shall confirm the possible death of an insured pursuant to paragraph (b)(i) of this section when the insurer maintains at least the following information on those covered under a policy:

(i) Social security number or name and date of birth;

(ii) Beneficiary designation;

(iii) Coverage eligibility;

(iv) Benefit amount; and

(v) Premium payment status.

(d) Every insurer shall implement procedures to account for all of the following:

(i) Common nicknames, initials used in lieu of a first or middle name, use of a middle name, compound first and middle names and interchanged first and middle names;

(ii) Compound last names, maiden or married names and hyphens, blank spaces or apostrophes in last names;

(iii) Transposition of the month and date within a date of birth;

(iv) Incomplete social security numbers.

(e) To the extent permitted by law, an insurer may disclose minimum necessary personal information about the insured or beneficiary to a person whom the insurer reasonably believes may be able to assist the insurer in locating the beneficiary.

(f) An insurer or its service provider shall not charge any beneficiary or other authorized representative for any fees or costs associated with a death master file search or verification of a death master file match conducted pursuant to this section.

(g) Benefits due and owing from a policy or a retained asset account, plus any applicable accrued contractual interest, shall first be payable to the designated beneficiary. If the beneficiary cannot be found, the insurer shall comply with the applicable provisions of the Uniform Unclaimed Property Act. Interest otherwise payable as required by law shall not be considered unclaimed property pursuant to W.S. 34-24-120(a).

(h) Once benefits and accrued contractual interest are presumed abandoned under W.S. 34-24-108, the insurer shall notify the state treasurer, as part of the report sent under W.S. 34-24-118, that:

(i) A beneficiary has not submitted a claim with the insurer; and

(ii) The insurer has complied with this section and has been unable, after good faith efforts documented by the insurer, to contact the beneficiary.

(j) Failure to meet any requirement of this section may constitute an unfair trade practice and is subject to the penalty provided in W.S. 26-1-107.

(k) As used in this section:

(i) "Death master file" means the United States social security administration's death master file or any other database or service that is at least as comprehensive as the United States social security administration's death master file for determining that a person has reportedly died;

(ii) "Death master file match" means a search of the death master file that results in a match of the social security number or the name and date of birth of an insured, annuity owner or retained asset account holder;

(iii) "Policy" means any policy or certificate of life insurance that provides a death benefit or any annuity contract, except that the term shall not include:

(A) Any policy or certificate of life insurance that provides a death benefit under an employee benefit plan that is:

(I) Subject to the Employee Retirement Income Security Act of 1974; or

(II) Part of a federal employee benefit program.

(B) Any policy or certificate of life insurance that is used to fund a prearranged funeral contract;

(C) Any policy or certificate of credit life or accidental death insurance;

(D) Any policy issued to a group master policyholder for which the insurer does not provide record keeping services; or

(E) An annuity used to fund an employment based retirement plan or program if the insurer:

(I) Does not perform the record keeping services; or

(II) Is not committed by terms of the annuity contract to pay death benefits to the beneficiaries of specific plan participants.

(iv) "Record keeping services" means services provided by an insurer for a group policy customer pursuant to

an agreement under which the insurer is responsible for obtaining, maintaining and administering, in its own or its agent's systems, at least the following information about each individual insured under the group policy or a line of coverage thereunder:

(A) Social security number or name and date of birth;

(B) Beneficiary designation information;

(C) Coverage eligibility;

(D) Benefit amount; and

(E) Premium payment status.

(v) "Retained asset account" means any mechanism whereby the settlement of proceeds payable under a policy is accomplished by the insurer or an entity acting on behalf of the insurer depositing the proceeds into an account with check or draft writing privileges, where those proceeds are retained by the insurer or its agent, pursuant to a supplementary contract not involving annuity benefits other than death benefits.

CHAPTER 17 - GROUP LIFE INSURANCE

26-17-101. Applicability of chapter; short title.

This chapter applies only to group life insurance and is known and may be cited as the "Group Life Insurance Law".

26-17-102. Group contracts must meet group requirements; inapplicability of section; old contracts saved.

(a) No life insurance policy shall be delivered or issued for delivery in this state insuring the lives of more than one (1) individual unless to one (1) of the groups specified in this chapter and unless in compliance with the provisions of this chapter.

(b) Subsection (a) of this section does not apply to life insurance policies:

(i) Insuring only individuals:

(A) Related by blood, marriage, legal adoption or common ethnic heritage or ancestry;

(B) Having a common interest through ownership of a business enterprise, or a substantial legal interest or equity therein, and who are actively engaged in the management thereof; or

(C) Otherwise having an insurable interest in each other's lives.

(ii) Repealed by Laws 1990, ch. 3, § 3.

(c) Subsections (a) and (b) of this section and W.S. 26-17-103 through 26-17-109 do not apply to any group life insurance contract entered into or issued prior to January 1, 1968 or to any transfer of that contract to, or rewriting of that contract by, another insurer.

26-17-103. Employee groups.

(a) The lives of a group of individuals may be insured under a policy issued to an employer or trustees of a fund established or adopted by an employer, which employer or trustee is deemed the policyholder, insuring the employer's employees for the benefit of persons other than the employer, subject to the following requirements:

(i) All employees or any class of employees are eligible for insurance under the terms of the policy;

(ii) The policy may define "employees" to include:

(A) The employees of one (1) or more subsidiary corporations;

(B) The employees, individual proprietors and partners of one (1) or more affiliated corporations, proprietors or partnerships, if the business of the employer and of the affiliated corporations, proprietors or partnerships is under common control through stock ownership, contract or otherwise;

(C) The individual proprietor or partner, if the employer is an individual proprietor or a partnership;

(D) Retired or former employees;

(E) Directors of a corporate employer.

(iii) Repealed by Laws 1990, ch. 3, § 3.

(iv) Repealed by Laws 1990, ch. 3, § 3.

(v) Any policy issued to insure the employees of a public body may define "employees" to include elected or appointed officials;

(vi) Policy premiums shall be paid by the policyholder subject to the following requirements:

(A) Repealed by Laws 1990, ch. 3, §§ 2, 3.

(B) Repealed by Laws 1990, ch. 3, § 3.

(C) Repealed by Laws 1990, ch. 3, § 3.

(D) If the insured employee does not pay any part of the premium for his insurance, the policy shall insure all eligible employees, except those who reject the coverage in writing and except as provided in subparagraph (E) of this paragraph;

(E) An insurer may exclude or limit the coverage on any person if evidence of individual insurability does not satisfy the insurer.

(vii) Repealed by Laws 1990, ch. 3, § 3.

(viii) Repealed by Laws 1990, ch. 3, § 3.

26-17-104. Debtor groups for benefit of creditor.

(a) The lives of a group of individuals may be insured under a policy issued to a creditor, a creditor's parent holding company or a trustee or agent designated by two (2) or more creditors, which creditor, holding company, affiliate, trustee or agent is deemed the policyholder, to insure debtors of the creditor concerning their indebtedness, subject to the following requirements:

(i) All debtors or any class of debtors of the creditor are eligible for insurance under the terms of the policy;

(ii) The policy may provide that the term "debtors" shall include:

(A) Borrowers of money or purchasers or lessees of goods, services or property for which payment is arranged through a credit transaction;

(B) The debtors of one (1) or more subsidiary corporations; and

(C) The debtors of one (1) or more affiliated corporations, proprietors or partnerships if the business of the policyholder and of the affiliated corporations, proprietors or partnerships is under common control.

(iii) Repealed by Laws 1990, ch. 3, § 3.

(iv) Policy premiums shall be paid by the policyholder, subject to the following requirements:

(A) Repealed by Laws 1990, ch. 3, § 3.

(B) Repealed by Laws 1990, ch. 3, § 3.

(C) If the insured debtor does not pay any part of the premium for his insurance, the policy shall insure all eligible debtors, except those who reject the coverage in writing and those who do not present evidence of individual insurability satisfactory to the insurer.

(v) Repealed by Laws 1990, ch. 3, § 3.

(vi) The policy may exclude from the classes eligible for insurance classes of debtors determined by age;

(vii) The total amount of insurance payable for an indebtedness shall not exceed the greater of the scheduled or actual amount of unpaid indebtedness to the creditor, except that insurance written concerning open-end credit having a credit limit exceeding ten thousand dollars ($10,000.00) may be in an amount not exceeding the credit limit;

(viii) The insurance may be payable to the creditor or any successor to the right, title and interest of the creditor. The payment shall reduce or extinguish the unpaid indebtedness of the debtor to the extent of the payment and any

excess of the insurance is payable to the insured or the estate of the insured;

(ix) Notwithstanding paragraphs (i) through (viii) of this subsection, insurance on agricultural credit transaction commitments may be written up to the amount of the loan commitment on a nondecreasing or level term plan. Insurance on educational credit transaction commitments may be written up to the amount of the loan commitment less the amount of any repayments made on the loan.

26-17-105. Labor union groups.

(a) The lives of a group of individuals may be insured under a policy issued to a labor union or similar employee organization which union or organization is deemed the policyholder, to insure members of the union or organization for the benefit of persons other than the union or organization or any of its officials, representatives or agents, subject to the following requirements:

(i) All members or any class of members of the union or organization are eligible for insurance under the terms of the policy;

(ii) Policy premiums shall be paid by the policyholder, subject to the following requirements:

(A) Repealed by Laws 1990, ch. 3, § 3.

(B) Repealed by Laws 1990, ch. 3, § 3.

(C) Repealed by Laws 1990, ch. 3, § 3.

(D) If the insured member does not pay any part of the premium for his insurance, the policy shall insure all eligible members, except those who reject the coverage in writing and those who do not present evidence of individual insurability satisfactory to the insurer.

(iii) Repealed by Laws 1990, ch. 3, § 3.

(iv) Repealed by Laws 1990, ch. 3, § 3.

26-17-106. Trustee groups.

(a) The lives of a group of individuals may be insured under a policy issued to a trust or the trustees of a fund established or adopted by two (2) or more employers, by one (1) or more labor unions or similar employee organizations, or by one (1) or more employers and one (1) or more labor unions or similar employee organizations, which trust or trustees are deemed the policyholder, to insure employees of the employers or members of the unions or organizations, for the benefit of persons other than the employers, unions or organizations, subject to the following requirements:

(i) No policy shall be issued to insure employees of any employer whose eligibility to participate in the fund as an employer arises out of considerations directly related to the employer being a commercial correspondent or business client or patron of another employer, except if the other employer exercises substantial control over the business operations of the participating employers;

(ii) All employees of the employers, members of the unions or organizations, or any classes of the employers, union members or organization members are eligible for insurance under the terms of the policy;

(iii) The policy may define "employees" to include:

(A) Retired or former employees;

(B) The individual proprietor or partners, if an employer is an individual proprietor or a partnership;

(C) The trustees, trustees' employees, or both, if their duties are principally connected with the trusteeship;

(D) Employees of one (1) or more subsidiary corporations and the employees, individual proprietors and partners of one (1) or more affiliated corporations, proprietorships or partnerships if the business of the employer and of the affiliated corporations, proprietorships or partnerships is under common control;

(E) Directors of a corporate employer.

(iv) Repealed by Laws 1990, ch. 3, § 3.

(v) Policy premiums shall be paid by the trustees subject to the following requirements:

(A) Repealed by Laws 1990, ch. 3, §§ 2, 3.

(B) Repealed by Laws 1990, ch. 3, § 3.

(C) If the covered person does not pay any part of the premium for his insurance, the policy shall insure all eligible persons, except those who reject the coverage in writing and those who do not present evidence of individual insurability satisfactory to the insurer.

(vi) Repealed by Laws 1990, ch. 3, § 3.

(vii) Repealed by Laws 1990, ch. 3, § 3.

26-17-107. Repealed by Laws 1990, ch. 3, § 3.

26-17-108. Dependents' coverage.

(a) Insurance under any group life insurance policy issued pursuant to W.S. 26-17-103, 26-17-105, 26-17-106, 26-17-109, 26-17-127 or 26-17-128 may be extended to insure the employees or members or any class of employees or members against loss due to the death of their spouses and dependent children:

(i) Repealed by Laws 1990, ch. 3, §§ 2, 3.

(ii) If the employer or member does not pay any part of the premium for the spouse's or dependent child's coverage, the policy shall insure all eligible employees or members with respect to their spouses and dependent children or any class of employees or members except that an insurer may exclude or limit the coverage on any spouse or dependent child if evidence of individual insurability does not satisfy the insurer;

(iii) Repealed By Laws 2009, Ch. 93, § 1.

(iv) Repealed by Laws 1990, ch. 3, § 3.

(b) Repealed by Laws 1990, ch. 3, § 3.

(c) Repealed by Laws 1990, ch. 3, § 3.

(d) Repealed by Laws 1990, ch. 3, § 3.

(e) Notwithstanding the provisions of W.S. 26-17-117, only one (1) certificate need be issued for each family unit if a

statement concerning any dependent's coverage is included in the certificate.

26-17-109. Credit union group.

(a) The lives of a group of individuals may be insured under a policy issued to a credit union or a trustee or agent designated by two (2) or more credit unions, which credit union, trustee or agent is deemed the policyholder, to insure members of the credit union for the benefit of persons other than the credit union, trustee, agent or any of their officials, subject to the following requirements:

(i) All members or all of any class of members of the credit union are eligible for insurance under the terms of the policy;

(ii) Policy premiums shall be paid by the policyholder from the credit union's funds and shall insure all eligible members except that an insurer may exclude or limit the coverage on any member if evidence of individual insurability does not satisfy the insurer.

(A) Repealed by Laws 1990, ch. 3, § 3.

(B) Repealed by Laws 1990, ch. 3, § 3.

(iii) Repealed by Laws 1990, ch. 3, § 3.

(B) Repealed by Laws 1990, ch. 3, § 3.

26-17-110. Provisions required in group contracts; exceptions.

(a) No group life insurance policy shall be delivered in this state unless it contains provisions conforming in substance to the provisions set forth in W.S. 26-17-110 through 26-17-121 and 26-17-130 or provisions which in the commissioner's opinion are more favorable to the persons insured, or at least as favorable to the persons insured and more favorable to the policyholder, except that:

(i) W.S. 26-17-116 through 26-17-120 and 26-17-130 do not apply to policies issued to a creditor to insure debtors of that creditor;

(ii) The standard provisions required for individual life insurance policies do not apply to group life insurance policies; and

(iii) If the group life insurance policy is on a plan of insurance other than the term plan, it shall contain a nonforfeiture provision which in the commissioner's opinion is equitable to the insured persons and to the policyholder, but nothing in this subsection requires that group life insurance policies contain the same nonforfeiture provisions as are required for individual life insurance policies.

26-17-111. Grace period.

The policyholder is entitled to a grace period of thirty-one (31) days for the payment of any premium due except the first. The death benefit coverage continues in force during the grace period, unless the policyholder gives 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 is liable to the insurer for the payment of a pro rata premium for the time the policy is in force during the grace period.

26-17-112. Incontestability.

The validity of the policy shall not be contested, except for nonpayment of premium, after it is in force for two (2) years from its date of issue. 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 the statement is made after the insurance is in force prior to the contest for a period of two (2) years during the person's lifetime nor unless it is contained in a written instrument he signs.

26-17-113. Application; statements are representations.

A copy of the policyholder's application, if any, shall be attached to the policy when issued and is a part of the contract. Any statements the policyholder or the persons insured make are representations and not warranties, and no statement any person insured makes shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to the person or, in the event of death or incapacity of the insured person, to his beneficiary or personal representative.

26-17-114. Evidence of insurability.

The policy shall set 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 his coverage.

26-17-115. Misstatement of age.

(a) The policy shall specify:

(i) That an equitable adjustment of premiums or of benefits or both shall be made in case the age of a person insured is misstated; and

(ii) The method of adjustment to be used.

26-17-116. Payment of benefits.

(a) Any sum due by reason of the death of the person insured is payable to the beneficiary designated by the person insured, except that if the policy refers to family status and does not specify family members by name, the beneficiary may be the family member specified by status in the policy, subject to:

(i) The provisions of the policy as to all or any part of the sum in case there is no designated beneficiary living at the time of the insured's death; and

(ii) Any right the insurer reserved in the policy and set forth in the certificate to pay at its option a part of the sum not exceeding two thousand dollars ($2,000.00) 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.

(b) Payment of benefits shall be subject to the interest provisions of W.S. 26-16-112 and time requirements of W.S. 26-15-124, provided the interest provisions of W.S. 26-16-112 shall not apply to variable contracts which provide for insurance or annuity benefits which may vary according to the investment experience of any separate account or accounts maintained by the insurer as to such contract.

26-17-117. Certificate of policyholders.

The insurer shall issue to the policyholder for delivery to each person insured an individual certificate with statements describing the insurance protection to which he is entitled, to whom the insurance benefits are payable, any dependent's coverage included in the certificate, and the rights and conditions set forth in W.S. 26-17-118 through 26-17-120 and 26-17-130.

26-17-118. Conversion on termination of eligibility.

(a) If the insurance, or any portion of it, on a person or dependent of a person covered under the policy ceases because of termination of employment or of membership in any of the classes eligible for coverage under the policy, the insurer shall offer to issue to him, without evidence of insurability, an individual life insurance policy without disability or other supplementary benefits, provided:

(i) Application for the policy shall be made, and the first premium paid to the insurer, within thirty-one (31) days after termination;

(ii) The policy, at the person's option, shall be on any one (1) of the forms 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;

(iii) The policy shall be in an amount not exceeding the amount of life insurance which ceases because of the termination less the amount of any life insurance for which the person is or becomes eligible under the same or any group policy within thirty-one (31) days after the termination, provided that any amount of insurance which matures on or before the date of such termination as an endowment payable to the person insured, whether in one (1) sum, in installments or in the form of an annuity, for the purposes of this provision, shall not be included in the amount which is considered to cease because of the termination; and

(iv) 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 the person then belongs and to his age attained on the effective date of the individual policy.

(b) Subject to the conditions set forth in subsection (a) of this section, the conversion privilege is available:

(i) To a surviving dependent, if any, at the death of the employee or member concerning the coverage under the group policy which terminates by reason of the death; and

(ii) To the dependent of the employee or member upon termination of the dependent's coverage if the employee or member remains insured under the group policy and if the dependent ceases to be a qualified family member under the group policy.

26-17-119. Conversion on termination of policy.

(a) If the group policy terminates or is amended to terminate the insurance of any class of insured persons, any person insured thereunder at the date of the termination whose insurance terminates, including the insured dependent of a covered person, which insured or insured dependent has been so insured for at least three (3) years prior to the termination date is entitled to have issued to him by the insurer an individual life insurance policy, subject to the same conditions provided by W.S. 26-17-118, except that the group policy shall provide that the amount of the individual policy is 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 any group policy issued or reinstated by the same or another insurer within thirty-one (31) days after the termination.

(i) Deleted by Laws 1990, ch. 3, § 2.

(ii) Repealed by Laws 1990, ch. 3, §§ 2, 3.

26-17-120. Death pending conversion.

If a person insured under the group policy, or the insured dependent of a covered person, dies during the period within which he would have been entitled to have an individual policy issued to him in accordance with W.S. 26-17-118 or 26-17-119 and before the individual policy is effective, the amount of life insurance which he would have been entitled to have issued under the individual policy is payable as a claim under the group policy, whether or not application for the individual policy or the payment of the first premium has been made.

26-17-121. Information to debtor insured under creditor's policy.

A policy issued to a creditor to insure debtors of the creditor shall contain a provision that the insurer shall furnish to the policyholder for delivery to each debtor insured under the policy a form which shall contain a statement that the life of the debtor is insured under the policy and that any death benefit paid thereunder by reason of his death shall first be applied to reduce or extinguish the indebtedness.

26-17-122. Notice as to conversion right.

If any individual insured under a group life insurance policy delivered in this state is entitled under the policy to have an individual life insurance policy issued to him without evidence of insurability, subject to making of application and payment of the first premium within the period specified in the policy, and if the individual is not given notice of the existence of that right at least fifteen (15) days prior to the expiration date of the period, the individual has an additional period within which to exercise the right, but nothing in this section continues any insurance beyond the period provided in the policy. This additional period shall expire fifteen (15) days immediately after the individual is given the notice, but no additional period shall extend beyond sixty (60) days immediately after the expiration date of the period provided in the policy. Written notice presented to the individual or mailed by the policyholder or the insurer to the individual's last known address as furnished by the policyholder constitutes notice for the purpose of this section.

26-17-123. Readjustment of premiums.

Any group life insurance contract may provide for a readjustment of the premium rate based upon the experience thereunder.

26-17-124. Application of dividends; rate reductions.

If a policy dividend is declared or a rate reduction is made or continued for any year of insurance under any group life insurance policy issued to any policyholder, the excess, if any, of the aggregate dividends or rate reductions under the policy and all other group insurance policies of the policyholder over the aggregate expenditure for insurance under the policies made from funds contributed by the policyholder, or by an employer of insured persons, or by a union or association to which the

insured persons belong, including expenditures made in connection with administration of the policies, shall be applied by the policyholder for the sole benefit of insured employees or members.

26-17-125. "Wholesale life insurance" defined.

(a) "Wholesale life insurance" means a plan of life insurance, other than salary savings life insurance or pension trust insurance and annuities, under which individual policies are issued:

(i) To the employees of any employer; and

(ii) On the lives of not less than four (4) employees at date of issue.

(b) Premiums for the policies shall be paid either wholly from the employer's funds, or funds the employer contributes, or partly from those funds and partly from funds the insured employees contribute.

26-17-126. Assignment of incidents of ownership under group life insurance policy.

(a) Subject to the terms of the policy, or pursuant to an agreement among the insured, the group policyholder and the insurer, any person insured under a group life insurance policy may assign to any person, other than the policyholder, any ownership or part thereof conferred on him by the policy or by the law, including specifically, but not limited to, the right to exercise the conversion privilege and the right to name a beneficiary.

(b) Any assignment by the insured is valid for the purpose of vesting in the assignee, in accordance with any provisions included therein as to the time at which it is effective, any ownership, rights, title and interest so assigned, but without prejudice to the insurer because of any payment it may make or individual policy it may issue prior to the receipt of notice of the assignment.

26-17-127. Additional groups.

(a) Group life insurance offered to a resident under a group life insurance policy issued to a group other than one

described in W.S. 26-17-103 through 26-17-106 and 26-17-109 is subject to the following requirements:

(i) A group life insurance policy shall not be delivered in this state unless the commissioner finds that:

(A) The issuance of the group policy is not contrary to the best interest of the public;

(B) The issuance of the group policy would result in economies of acquisition or administration;

(C) The benefits are reasonable in relation to the premiums charged;

(D) The insurer possesses and maintains capital and surplus requirements provided by W.S. 26-3-108.

(ii) Group life insurance coverage shall not be offered in this state by an insurer under a policy issued in another state unless the commissioner determines the requirements of paragraph (i) of this subsection are met and the insurer files with the commissioner:

(A) A copy of the group master contract;

(B) A copy of the statute of the state where the group policy is issued that authorizes the issuance of the group policy;

(C) Evidence of approval of the group policy in the state where the group policy is issued; and

(D) Copies of all supportive material used by the insurer to secure approval of the group in the state where the group policy is issued.

(iii) If the commissioner fails to make the determination provided by paragraph (ii) of this subsection within forty-five (45) days of filing by the insurer of the documents required by paragraph (ii) of this subsection, the requirements of paragraph (i) of this subsection are deemed to be met;

(iv) An insurer may exclude or limit the coverage on any person if evidence of individual insurability does not satisfy the insurer.

26-17-128. Insurance for associations.

(a) The lives of a group of individuals may be insured under a policy issued to an association or a trust or the trustee of a fund established or adopted for the benefit of members of one (1) or more associations. The association shall have at the time the policy is first issued a minimum of fifty (50) persons eligible for insurance, shall have been organized and maintained in good faith for purposes other than that of obtaining insurance, shall have been in active existence for at least one (1) year and shall have a constitution and bylaws which provide that:

(i) The association holds regular meetings not less than annually to further the members' purposes;

(ii) Except for credit unions, the association collects dues or solicits contributions from members; and

(iii) The members have voting privileges and representation on the governing board and committees.

(b) The policy allowed by subsection (a) of this section is subject to the following requirements:

(i) The policy may insure one (1) or more of the following or all of any class of the following for the benefit of persons other than the employee's employer:

(A) Members of the association;

(B) Employees of the association; or

(C) Employees of members.

(ii) If the covered person does not pay any part of the premium for his insurance, the policy shall insure all eligible persons, except those who reject the coverage in writing and except as provided in paragraph (iii) of this subsection; and

(iii) An insurer may exclude or limit the coverage on any person if evidence of individual insurability does not satisfy the insurer.

26-17-129. Notice of compensation.

(a) The insurer shall distribute to prospective insureds a written notice that compensation shall or may be paid for a program of insurance which if issued on a group basis would qualify under W.S. 26-17-127 or 26-17-128, if compensation of any kind shall or may be paid to:

(i) A policyholder or sponsoring or endorsing entity in the case of a group policy; or

(ii) A sponsoring or endorsing entity in the case of individual, blanket or franchise policies marketed by means of direct response solicitation.

(b) Notice required by this section shall be distributed:

(i) Whether compensation is direct or indirect; and

(ii) Whether compensation is:

(A) Paid to or retained by the policyholder or sponsoring or endorsing entity; or

(B) Paid to or retained by a third party at the direction of the policyholder, sponsoring or endorsing entity or any entity affiliated by way of ownership, contract or employment.

(c) The notice required by this section shall be placed on or accompany any application or enrollment form provided to prospective insureds.

(d) As used in this section:

(i) "Direct response solicitation" means a solicitation through a sponsoring or endorsing entity by the mails, telephone or other mass communications media; and

(ii) "Sponsoring or endorsing entity" means an organization which has arranged for the offering of a program of insurance in a manner which communicates that eligibility for participation in the program is dependent upon affiliation with the organization or that it encourages participation in the program.

26-17-130. Continuation during disability.

(a) Where active employment is a condition of insurance, the group policy shall contain a provision that an insured may continue coverage during the insured's total disability as provided in this subsection 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 not beyond the earlier of:

(i) Six (6) months from the date on which the total disability started;

(ii) Approval by the insurer of continuation of the coverage under any disability provision contained in the group insurance policy; or

(iii) The discontinuance of the group insurance policy.

CHAPTER 18 - DISABILITY INSURANCE POLICIES

ARTICLE 1 - GENERAL PROVISIONS

26-18-101. Short title.

This chapter may be cited as the "Uniform Disability Policy Provision Law".

26-18-102. Scope and applicability of chapter.

(a) Nothing in this chapter applies to or affects:

(i) Any policy of liability or worker's compensation insurance with or without supplementary expense coverage therein;

(ii) Any group or blanket policy;

(iii) Life insurance, endowment or annuity contracts, or contracts supplemental thereto which contain only those provisions relating to disability insurance as:

(A) Provide additional benefits in case of death or dismemberment or loss of sight by accident or accidental means; or

(B) Operate to safeguard the contracts against lapse, or to give a special surrender value or special benefit or an annuity in case the insured or annuitant is totally and permanently disabled as defined by the contract or supplemental contract.

(iv) Reinsurance;

(v) Any contract made or issued prior to January 1, 1968, together with any extensions, renewals, reinstatements or modifications thereof or amendments thereto whenever made.

26-18-103. General requirements for policies.

(a) No disability insurance policy shall be delivered or issued for delivery to any person in this state unless it otherwise complies with this code and the following:

(i) The entire money and other considerations therefor shall be expressed in the policy;

(ii) The time when the insurance takes effect and terminates shall be expressed in the policy;

(iii) It shall purport to insure only one (1) person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family, who is deemed the policyholder, any two (2) or more eligible members of that family, including husband, wife, dependent children or any children under a specified age not exceeding nineteen (19) years and any other person dependent upon the policyholder;

(iv) The style, arrangement and overall appearance of the policy shall give no undue prominence to any portion of the text, and any printed portion of the text and any endorsements or attached papers shall be plainly printed in lightfaced type of a style in general use, the size of which shall be uniform and not less than ten (10) point with a lower case unspaced alphabet length not less than one hundred twenty (120) point;

(v) The "text" shall include all printed matter except the insurer's name and address, the policy name or title, the brief description, if any, and captions and subcaptions;

(vi) The exceptions and reductions of indemnity shall be set forth in the policy and, other than those contained in

W.S. 26-18-105 through 26-18-127, shall be printed, at the insurer's option, either included with the benefit provision to which they apply or under an appropriate caption such as "Exceptions", or "Exceptions and Reductions", except that if an exception or reduction specifically applies to a particular policy benefit, a statement of that exception or reduction shall be included with the benefit provision to which it applies;

(vii) Each form, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page;

(viii) The policy shall not contain any provision purporting to make any portion of the insurer's charter, rules, constitution or bylaws a part of the policy unless that portion is set forth in full in the policy, except in the case of the incorporation of or reference to a statement of rates, classification of risks or short-rate table filed with the commissioner;

(ix) Repealed by Laws 2025, ch. 114, § 2.

(b) Repealed by Laws 2025, ch. 114, § 2.

26-18-104. Standard policy provisions; substitutions and omissions.

(a) Except as provided in subsection (b) of this section, any policy delivered or issued for delivery to any person in this state shall contain the provisions specified in W.S. 26-18-105 through 26-18-116, in the words in which the provisions appear, except that with the commissioner's approval the insurer may substitute for any of the provisions corresponding provisions of different wording which are in each instance not less favorable in any respect to the insured or the beneficiary. Each such provision shall be preceded individually by the applicable caption shown, or, at the insurer's option, by any appropriate individual or group captions or subcaptions the commissioner approves.

(b) If any provision or part thereof is inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the commissioner's approval, shall omit from the policy the inapplicable provision or part and shall modify any inconsistent provision or part to make the provision as contained in the policy consistent with the coverage the policy provides.

26-18-105. Policy constitutes entire contract; changes in policy.

"Entire Contract; Changes: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy is valid until approved by an executive officer of the insurer and unless the approval is endorsed on or attached to this policy. No agent has authority to change this policy or to waive any of its provisions."

26-18-106. Time limit on certain defenses.

(a) "Time Limit on Certain Defenses: After three (3) years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for the policy shall be used to void the policy or to deny a claim for loss incurred or disability, as defined in the policy, commencing after the expiration of the three (3) year period."

(i) This time limit shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during the initial three (3) year period, nor to limit the application of W.S. 26-18-118 through 26-18-121 in case of misstatement with respect to age or occupation or other insurance;

(ii) A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium until at least age fifty (50) or in the case of a policy issued after age forty-four (44), for at least five (5) years from its date of issue, may contain instead of the "time limit on certain defenses" provision of this section the following provision (from which paragraph (i) of this subsection may be omitted at the insurer's option) under the caption "Incontestable: After this policy is in force for a period of three (3) years during the insured's lifetime, excluding any period during which the insured is disabled, it is incontestable as to the statements contained in the application."

(b) "Except for the preexisting condition provision stated in this subsection, no claim for loss incurred or disability, as defined in the policy, shall be reduced or denied due to a preexisting condition not excluded from coverage by name or specific description effective on the date of loss. This

preexisting condition provision shall not exclude coverage for a period beyond twelve (12) months following the individual's effective date of coverage and shall only relate to conditions for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage or as to a pregnancy existing on the effective date of coverage."

(c) In determining whether a preexisting condition provision applies to an insured or dependent, all private or public health benefit plans shall credit the time the person was previously covered by a private or public health benefit plan if the previous coverage was continuous to a date not more than ninety (90) days prior to the effective date of the new coverage. In the case of a preexisting conditions limitation allowable in the succeeding carrier's plan, the level of benefits applicable to preexisting conditions or persons becoming covered by the succeeding carrier's plan during the period of time this limitation applies under the new plan shall be the lesser of:

(i) The benefits of the new plan determined without application of the preexisting conditions limitation; or

(ii) The benefits of the prior plan.

26-18-107. Grace period.

(a) "A grace period of .... (insert a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies) days shall be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force."

(b) A policy in which the insurer reserves the right to refuse any renewal shall have at the beginning of the provision specified in subsection (a) of this section: "Unless not less than five (5) days prior to the premium due date the insurer delivers to the insured or mails to his address, as shown by the insurer's records, written notice of its intention not to renew this policy beyond the period for which the premium has been accepted."

26-18-108. Reinstatement.

(a) "Reinstatement: If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent authorized by the insurer to accept the premium, without requiring an application for reinstatement, reinstates the policy. If the insurer or the agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy shall be reinstated upon the insurer's approval of the application, or, lacking that approval, upon the forty-fifth day following the date of the conditional receipt unless the insurer previously notified the insured in writing of its disapproval of the application. The reinstated policy covers only loss resulting from an accidental injury sustained after the date of reinstatement and loss due to any sickness beginning more than ten (10) days after that date. In all other respects the insured and insurer have the same rights under the policy as they had immediately before the due date of the defaulted premium, subject to any provisions endorsed on or attached to this policy in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement."

(b) The last sentence of the provision in subsection (a) of this section may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums:

(i) Until at least age fifty (50); or

(ii) In the case of a policy issued after age forty-four (44), for at least five (5) years from its date of issue.

26-18-109. Notice of claim; loss-of-time benefit.

(a) "Notice of Claim: Written notice of claim shall be given to the insurer within sixty (60) days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at .... (insert the location of the office the insurer designates for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, is deemed notice to the insurer."

(b) In a policy providing a loss-of-time benefit which may be payable for at least two (2) years, an insurer may insert the following between the first and second sentence of the provision specified in subsection (a) of this section: "Subject to the qualifications set forth in this provision, if the insured suffers loss of time because of disability for which indemnity is payable for at least two (2) years, at least once in every six (6) months after having given notice of the claim, he shall give to the insurer notice of continuance of the disability, except in the event of legal incapacity. The period of six (6) months following any filing of proof by the insured or any payment by the insurer because of the claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in giving the notice does not impair the insured's right to any indemnity which would otherwise have accrued during the period of six (6) months preceding the date on which the notice is actually given."

26-18-110. Claim forms.

"Claim Forms: The insurer, upon receipt of a notice of claim, will furnish to the claimant the forms it usually furnishes for filing proofs of loss. If the forms are not furnished within fifteen (15) days after giving notice, the claimant is deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and extent of the loss for which claim is made."

26-18-111. Proofs of loss.

"Proofs of Loss: Written proof of loss shall be furnished to the insurer at its office in case of claim for loss for which this policy provides any periodic payment, contingent upon continuing loss within ninety (90) days after the termination of the period for which the insurer is liable, and in case of claim for any other loss within ninety (90) days after the date of the loss. Failure to furnish proof within the time required does not invalidate nor reduce any claim if it is not reasonably possible to give proof within that time, provided the proof is furnished as soon as reasonably possible and, except in the absence of legal capacity, not later than one (1) year from the time proof is otherwise required."

26-18-112. Time of payment of claims.

"Time of Payment of Claims: Indemnities payable under this policy for any loss, other than loss for which this policy provides any periodic payment, shall be paid immediately upon receipt of written proof of the loss. Subject to written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment shall be paid .... (insert period for payment which shall not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability shall be paid immediately upon receipt of written proof."

26-18-113. Payment of claims.

(a) "Payment of Claims: Indemnity for loss of life is payable in accordance with the beneficiary designation and the provisions respecting that payment which may be prescribed in this policy and effective at the time of payment. If no designation or provision is then effective, the indemnity is payable to the insured's estate. Any other accrued indemnities unpaid at the insured's death, at the insurer's option, may be paid either to the beneficiary or to the estate. Any other indemnities are payable to the insured."

(b) Either or both of the following provisions may be included with the provision specified in subsection (a) of this section at the insurer's option:

(i) "If any indemnity of this policy is payable to the insured's estate, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay the indemnity, up to an amount not exceeding $.... (insert an amount which shall not exceed $1,000), to any relative by blood or connection by marriage of the insured or beneficiary whom the insurer deems to be equitably entitled thereto. Any payment the insurer makes in good faith pursuant to this provision discharges the insurer to the extent of the payment."

(ii) "Subject to the insured's written direction in the application or otherwise, all or a portion of any indemnities provided by this policy because of hospital, nursing, medical or surgical services, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of the loss, may be paid directly to the hospital or person rendering the services, but it is not required that the service be rendered by a particular hospital or person."

26-18-114. Physical examination and autopsy.

"Physical Examinations and Autopsy: The insurer at its own expense has the right to examine the person of the insured when and as often as it reasonably requires during the pendency of a claim under the policy and to make an autopsy in case of death if it is not forbidden by law."

26-18-115. Legal actions.

"Legal Actions: No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty (60) days after written proof of loss is furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished."

26-18-116. Change of beneficiary.

(a) "Change of Beneficiary: Unless the insured makes an irrevocable designation of beneficiary, the right to change the beneficiary is reserved to the insured, and the consent of the beneficiary is not requisite to the surrender or assignment of this policy or to any change of beneficiary, or to any other changes in this policy."

(b) The clause relating to the irrevocable designation of beneficiary may be omitted at the insurer's option.

26-18-117. Optional policy provisions.

Except as provided in W.S. 26-18-104(b), no disability insurance policy delivered or issued for delivery to any person in this state shall contain provisions as set forth in W.S. 26-18-118 through 26-18-127 unless the wording of those provisions is the same as it appears in the applicable section, except that the insurer may use a corresponding provision of different wording the commissioner approves which is not less favorable in any respect to the insured or the beneficiary. The corresponding provision shall be preceded individually by the appropriate caption or, at the insurer's option, by appropriate individual or group captions or subcaptions the commissioner approves.

26-18-118. Change of occupation.

"Change of Occupation: If the insured is injured or becomes ill after having changed his occupation to one the insurer

classifies as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer shall pay only that portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for the more hazardous occupation. If the insured changes his occupation to one the insurer classifies as less hazardous than that stated in this policy, the insurer, upon receipt of proof of the change of occupation, shall reduce the premium rate accordingly, and shall return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of the proof, whichever is more recent. In applying this provision, the classification of occupational risk and the premium rates shall be those the insurer last filed, prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation, with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued. If the filings specified were not required, then the classification of occupational risk and the premium rates shall be those the insurer last made effective in that state prior to the occurrence of the loss or prior to the date of proof of change in occupation."

26-18-119. Misstatement of age.

"Misstatement of Age: If the insured's age is misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age."

26-18-120. Overinsurance; same insurer.

"If any accident or sickness or accident and sickness policy previously issued by the insurer to the insured is in force concurrently with this policy, making the aggregated indemnity for .... (insert type of coverage or coverages) in excess of $.... (insert maximum limit of indemnity or indemnities), the excess insurance is void and all premiums paid for the excess shall be returned to the insured or to his estate." or, instead: "Insurance effective at any one time on the insured under this policy and a like policy in this insurer is limited to one (1) policy the insured, his beneficiary or his estate elects, and the insurer shall return all premiums paid for the other policies."

26-18-121. Overinsurance; all coverages.

(a) "Overinsurance: If, with respect to a person covered under this policy, benefits for allowable expense incurred during a claim determination period under this policy together with benefits for allowable expense during that period under all other valid coverage, without giving effect to this provision or to any 'overinsurance provision' applying to the other valid coverage, exceed the total of the person's allowable expense during the period, this insurer is liable only for the proportionate amount of the benefits for allowable expense under this policy during the period as:

(i) The total allowable expense during the period bears to:

(A) The total amount of benefits payable during the period for the expense under this policy and all other valid coverage, without giving effect to this provision or to any 'overinsurance provision' applying to the other valid coverage; less

(B) In this paragraph any amount of benefits for allowable expenses payable under other valid coverage which does not contain an overinsurance provision.

(b) The provisions of subsection (a) of this section do not operate to increase the amount of benefits for allowable expense payable under this policy with respect to a person covered under this policy above the amount which would have been paid in the absence of these provisions. This insurer may pay benefits to any insurer providing other valid coverage in case of overpayment by the insurer. Any such payment discharges this insurer's liability as fully as if the payment is made directly to the insured, his assignee or his beneficiary. If this insurer pays benefits to the insured, his assignee or his beneficiary, exceeding the amount payable if the existence of other valid coverage had been disclosed, this insurer has a right of action against the insured, his assignee or his beneficiary to recover the amount which would not have been paid had there been a disclosure of the existence of other valid coverage. The amount of other valid coverage which is on a provision of service basis shall be computed as the amount the services rendered would have cost in the absence of that coverage.

(c) For the purpose of the provisions in subsections (a) and (b) of this section:

(i) 'Allowable expense' means one hundred ten percent (110%) of any necessary, reasonable and customary item of expense which is covered, in whole or part, as a hospital, surgical, medical or major medical expense under this policy or under any other valid coverage;

(ii) 'Claim determination period' with respect to any covered person means the initial period of .... (insert period of not less than thirty days) and each successive period of a like number of days, during which allowable expense covered under this policy is incurred because of that person. The first period begins on the date when the first expense is incurred, and successive periods begin when an expense is incurred after expiration of a prior period, or, instead: 'Claim determination period' with respect to any covered persons means .... (insert calendar or policy period of not less than a month) during which allowable expense covered under this policy is incurred because of that person;

(iii) 'Overinsurance provision' means this provision and any other provision which may reduce an insurer's liability because of the existence of benefits under other valid coverage."

(d) The policy provisions specified in subsections (a) through (c) of this section may be inserted in all policies providing hospital, surgical, medical or major medical benefits. The insurer may make this provision applicable to either or both other valid coverage with other insurers and other valid coverage with the same insurer. The insurer shall include in this provision a definition of "other valid coverage" approved as to form by the commissioner. The term may include hospital, surgical, medical or major medical benefits provided by group, blanket or franchise coverage, individual and family-type coverage, Blue Cross-Blue Shield coverage and other prepayment plans, group practice and individual practice plans, uninsured benefits provided by labor-management trusteed plans, or union welfare plans, or by employer or employee benefit organizations, benefits provided under governmental programs, worker's compensation insurance or any coverage required or provided by any other statute, and medical payments under automobile liability and personal liability policies. Other valid coverage does not include payments made under third party liability coverage as a result of a determination of negligence, but an insurer may include a subrogation clause in its policy. As part of the proof of claim, the insurer may require the information necessary to administer this provision.

26-18-122. Relation of earnings to insurance.

(a) "After the loss-of-time benefit of this policy has been payable for ninety (90) days, that benefit shall be adjusted, as provided in this section, if the total amount of unadjusted loss-of-time benefits provided in all valid loss-of-time coverage upon the insured exceeds .... % of the insured's earned income. However, if the information contained in the application discloses that the total amount of loss-of-time benefits under this policy and under all other valid loss-of-time coverage expected to be effective upon the insured in accordance with the application for this policy exceeded .... % of the insured's earned income at the time of the application, the higher percentage shall be used in the place of .... %. The adjusted loss-of-time benefit under this policy for any month shall be only that proportion of the loss-of-time benefit otherwise payable under this policy as:

(i) The product of the insured's earned income and .... % or, if higher, the alternative percentage described at the end of the first sentence of this provision bears to;

(ii) The total amount of loss-of-time benefits payable for that month under this policy and all other valid loss-of-time coverage on the insured, without giving effect to the overinsurance provision in this or any other coverage; less

(iii) In both paragraphs (i) and (ii) of this subsection any amount of loss-of-time benefits payable under other valid loss-of-time coverage which does not contain an 'overinsurance provision'.

(b) In making the computation specified in subsection (a) of this section, all benefits and earnings shall be converted to a consistent (insert 'weekly' if the loss-of-time benefit of this policy is payable weekly, 'monthly' if the benefit is payable monthly, etc.) basis. If the numerator of the ratio obtained in the computation in subsection (a) of this section is zero or is negative, no benefit is payable under this policy. This provision does not operate to:

(i) Reduce the total combined amount of loss-of-time benefits for the month payable under this policy and all other valid loss-of-time coverage below the lesser of three hundred dollars ($300.00) and the total combined amount of loss-of-time

benefits determined without giving effect to any 'overinsurance provision';

(ii) Increase the amount of benefits payable under this policy above the amount which would have been paid in the absence of this provision; nor

(iii) Take into account or reduce any benefit other than the loss-of-time benefit.

(c) For the purpose of subsections (a) and (b) of this section:

(i) 'Earned income', unless otherwise specified, means the greater of the monthly earnings of the insured at the time disability commences and his average monthly earnings for a period of two (2) years immediately preceding the commencement of that disability and does not include any investment income or any other income not derived from the insured's vocational activities;

(ii) 'Overinsurance provision' includes this provision and any other provision with respect to any loss-of-time coverage which may have the effect of reducing an insurer's liability if the total amount of loss-of-time benefits under all coverage exceeds a stated relationship to the insured's earnings."

(d) The provisions of subsections (a) through (c) of this section may be included only in a policy providing a loss-of-time benefit which is payable for at least fifty-two (52) weeks, which is issued on the basis of selective underwriting of each individual application and for which the application includes a question designed to elicit information necessary either to determine the ratio of the total loss-of-time benefits of the insured to the insured's earned income or to determine that the ratio does not exceed the percentage of earnings, not less than sixty percent (60%), the insurer selects and inserts instead of the blank factor specified in this section. As part of the proof of claim, the insurer may require the information necessary to administer this provision. If the application indicates that other loss-of-time coverage is to be discontinued, the amount of the other coverage shall be excluded in computing the alternative percentage in the first sentence of the overinsurance provision.

(e) The policy shall include a definition of "valid loss-of-time coverage", which the commissioner approves as to form. The definition may include:

(i) Coverage provided by:

(A) Governmental agencies; and

(B) Organizations subject to regulation by insurance law and by insurance authorities of this or any other state of the United States or of any other country or subdivision thereof.

(ii) Coverage provided for the insured pursuant to:

(A) Any disability benefits statute; or

(B) Any worker's compensation or employer's liability statute.

(iii) Benefits provided by labor-management trusteed plans, union welfare plans, employer or employee benefit organizations or by salary continuance or pension programs; and

(iv) Any other coverage the inclusion of which the commissioner approves.

26-18-123. Unpaid premiums.

"Unpaid Premiums: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted from the amount of the claim paid."

26-18-124. Conformity with state statutes.

"Conformity with State Statutes: Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on that date is amended to conform to the minimum requirements of those statutes."

26-18-125. Illegal occupation.

"Illegal Occupation: The insurer is not liable for any loss to which a contributing cause is the insured's commission of or

attempt to commit a felony or to which a contributing cause is the insured's engaging in an illegal occupation."

26-18-126. Intoxicants and narcotics.

"Intoxicants and Narcotics: The insurer is not liable for any loss sustained or contracted because of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician."

26-18-127. Renewability.

(a) Disability insurance policies, other than accident insurance only policies, in which the insurer reserves the right to refuse renewal on an individual basis, shall provide in substance in a provision in the policy or in an endorsement thereon or rider attached thereto that:

(i) Subject to the right to terminate the policy upon nonpayment of premium when due, the right to refuse renewal may not be exercised so as to take effect before the renewal date occurring on, or after and nearest, each policy anniversary (or in the case of lapse and reinstatement, at the renewal date occurring on, or after and nearest, each anniversary of the last reinstatement); and

(ii) Any refusal of renewal is without prejudice to any claim originating while the policy is in force.

(b) The insurer may omit the parenthetic reference to lapse and reinstatement in paragraph (a)(i) of this section.

26-18-128. Order of provisions of policy.

The provisions specified in W.S. 26-18-105 through 26-18-127 or any corresponding provisions used instead of the provisions in those sections shall be printed in the consecutive order of the provisions in W.S. 26-18-105 through 26-18-127 or, at the insurer's option, any such provision may appear as a unit in any part of the policy, with other provisions to which it is logically related, provided that the resulting policy shall not be in any part unintelligible, ambiguous or likely to mislead a person to whom the policy is offered, delivered or issued.

26-18-129. Third-party ownership.

"Insured", as used in this chapter, shall not be construed as preventing a person, other than the insured, with a proper insurable interest from making application for and owning a policy covering the insured or from being entitled under that policy to any indemnities, benefits and rights provided therein.

26-18-130. Requirements of other jurisdictions.

Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this state, may contain any provision which is not less favorable to the insured or the beneficiary than the provisions of this chapter and which is prescribed or required by the law of the state or country under which the insurer is organized.

26-18-131. Policies issued for delivery in another state.

If any policy is issued by a domestic insurer for delivery to a person residing in another state, and if the insurance commissioner or corresponding public official of the other state informs the commissioner that the policy is not subject to approval or disapproval by the official, the commissioner, by ruling, may require that the policy meet the standards set forth in W.S. 26-18-103 through 26-18-130.

26-18-132. Policies less favorable than provisions of chapter prohibited.

Any policy provision which is not subject to this chapter shall not make a policy, or any portion thereof, less favorable in any respect to the insured or the beneficiary than the provisions of the policy which are subject to this chapter.

26-18-133. Age limit.

If a policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy is not effective, and if that date falls within a period for which the insurer accepts a premium or if the insurer accepts a premium after that date, the coverage provided by the policy continues in force until the end of the period for which premium is accepted. If the insured's age is misstated and if according to the insured's correct age the coverage provided by the policy would not be effective, or would cease prior to the acceptance of the premium, the insurer's liability is limited to the refund, upon request, of all premiums paid for the period not covered by the policy.

26-18-134. Prohibited policy plans and provisions.

(a) No insurer shall deliver or issue for delivery in this state any disability insurance policy:

(i) Providing benefits or values for surviving or continuing policyholders contingent upon the lapse or termination for any reason of other policyholders policies;

(ii) Containing any clause, provision or agreement providing a premium, deposit or other payment for, or promising the distribution of, any bonus, special fund or guaranteed payment other than the insurance benefits specified in the policy, except that this restriction does not apply to the payment of dividends to the holders of participating policies.

26-18-135. Filing of rates; adherence to rates filed.

Each insurer issuing disability insurance policies for delivery in this state, before use thereof, shall file with the commissioner its premium rates and classification of risks pertaining to the policies. The insurer shall adhere to its rates and classifications as filed with the commissioner. The insurer may change the filings as it deems proper.

26-18-136. Franchise disability insurance.

(a) Disability insurance on a franchise plan is that form of disability insurance issued to:

(i) Four (4) or more employees of any corporation, copartnership or individual employer or any governmental corporation, agency or department thereof; or

(ii) Ten (10) or more members, employees or employees of members of any labor union or of any trade, professional or other association which:

(A) Has a constitution or bylaws; and

(B) Repealed by Laws 2003, Ch. 160, § 2.

(C) Issues to the persons specified in this paragraph, with or without their dependents, the same form of an individual policy varying only as to amounts and kinds of coverage applied for by those persons under an arrangement in

which the premiums on the policies may be paid to the insurer periodically by:

(I) The employer, with or without payroll deductions;

(II) The association or union for its members; or

(III) Some designated person acting on behalf of the employer, association or union.

(b) "Employees", as used in this section, includes the officers, managers, employees and retired employees of the employer and the individual proprietor or partners if the employer is an individual proprietor or partnership.

(c) Prior to marketing or offering any disability insurance for a franchise plan formed for the sole purpose of obtaining insurance, the producer shall file a written report with the department setting forth the name of the entity or entities, the insurer and its address and the offering producer and his address. The department shall keep the name of the association confidential.

(d) The provisions of the Small Employer Health Insurance Availability Act, W.S. 26-19-301 et seq., shall apply to all insurance issued under this section.

26-18-137. Repealed by Laws 1990, ch. 15, § 3.

ARTICLE 2 - MULTI-STATE COOPERATION

26-18-201. Definitions.

(a) As used in this article:

(i) "Comprehensive individual medical and surgical insurance policy" shall have the same meaning as "health benefit plan" as that term is defined in W.S. 26-19-302(a)(xii), including, at a minimum, comprehensive major medical coverage for medical and surgical benefits;

(ii) "Health insurance," "health benefit plan" and "health benefit policy" mean a health benefit plan as defined by W.S. 26-19-302(a)(xii);

(iii) "High deductible health plan" means accident and sickness insurance plans sold or maintained under the applicable provisions of section 223 of the Internal Revenue Code;

(iv) "Primary state" means the state designated by the issuer as the state whose covered laws shall govern the health insurance issuer in the sale of health insurance coverage;

(v) "Secondary state" means any state that is not the primary state.

26-18-202. Sale of medical and surgical insurance policies approved in identified other states.

In accordance with the provisions of this article, the commissioner shall identify at least five (5) states with insurance laws sufficiently consistent with Wyoming laws. The commissioner may approve for sale in Wyoming selected comprehensive individual medical and surgical insurance policies that have been approved for issuance in those other states where the insurer is authorized to engage in the business of insurance so long as the insurer is also authorized to engage in the business of insurance in this state and provided that the policy meets the requirements set forth in this article. High deductible health plans that meet national standards for comprehensive medical and surgical coverage may be among the policies automatically approved in Wyoming if approved in the states identified as acceptable by the commissioner.

26-18-203. Approval of policies.

A policy approved and issued pursuant to this article shall be treated as if it were issued by an insurer domiciled in Wyoming regardless of the insurer's actual domiciliary.

26-18-204. Financial requirements; continuing compliance.

(a) Any insurer selling an insurance policy pursuant to this article, and any plan approved under this article, shall satisfy actuarial standards and insurer solvency requirements set forth by the National Association of Insurance Commissioners (NAIC) and adopted by regulation promulgated by the commissioner or as otherwise prescribed by regulation promulgated by the commissioner so long as the regulation is not inconsistent with NAIC standards.

(b) Any policy sold in Wyoming under the coverage and administrative laws and regulations of another state that are not covered by a guarantee association or similar association of that state shall be protected under the Wyoming Life and Health Insurance Guaranty Association Act under Chapter 42 of this title.

(c) The commissioner shall have the authority to determine whether an insurer satisfies the standards required by this section and shall not approve a policy or plan that he finds not in compliance with this section. The commissioner shall have the authority to determine whether the policies sold pursuant to this article continue to satisfy the requirements set forth in this section in the same manner as he does with an individual accident and sickness insurance policy approved pursuant to this code. The commissioner shall have the authority to suspend or revoke new sales of out-of-state policies if the laws and regulations of those states are determined to egregiously harm Wyoming residents. Upon suspension or revocation, the issuers of the out-of-state policies shall be required to notify in writing all affected Wyoming policyholders of the suspension or revocation determination by the commissioner.

26-18-205. Multi-state consortium; reciprocity requirements.

(a) The commissioner shall explore with other insurance commissioners the creation of a consortium of like-minded states that could establish rules of reciprocity for the approval of comprehensive individual medical and surgical health insurance policies among the participating states.

(b) The commissioner shall solicit the thoughts and report a consensus, where one exists, of the other commissioners interested in creating a consortium of like minded states in establishing rules of reciprocity for the approval of health insurance policies. Issues to be considered include but are not limited to:

(i) Whether the consortium should involve only high deductible individual policies, all comprehensive individual medical and surgical health insurance policies, both of these types of individual policies plus small group policies or all health insurance policies;

(ii) Whether insurers should be free to price differently among consortium states dependent on local health care costs and market conditions;

(iii) Whether a policy approved in a primary state shall be automatically available in all secondary states of the consortium, or available at the option of the insurer;

(iv) In areas where an associated preferred provider network is absent, whether sale of policies should be prohibited, disclaimers should be required or the sale of policies should be regulated only by market forces and conditions;

(v) The adequacy for a multi-state consortium of existing state laws on insurer financial solvency, guarantee funds and imposition and collection of premium taxes;

(vi) The authority of a secondary state to deal with customer complaints concerning a multi-state policy;

(vii) Whether and when an insurer selling a policy approved in a primary state must notify the commissioner of a secondary state that the insurer is marketing the policy in the secondary state;

(viii) Whether secondary state insurers, in order to sell competitive policies, may match any less restrictive primary state rules governing policies sold in the secondary state, and whether disclaimers to warn potential customers shall be required on policies and promotional materials in the secondary state;

(ix) Whether any of the issues identified in this subsection require the enactment of uniform laws in the consortium states;

(x) Estimated savings to customers from policy approval only in the primary state and from uniform or less restrictive policies across the consortium states;

(xi) Other issues deemed appropriate by the commissioners to implement a multi-state consortium.

(c) The commissioner shall make an initial proposal that Wyoming recommends the rules of approval for reciprocity should

include terms and conditions to protect customers similar to the following:

(i) An issuer, with respect to a particular policy, may only designate one (1) state as its primary state with respect to all coverage it offers using that policy. An issuer may not change the designated primary state with respect to individual health insurance coverage once the policy is issued; provided, however, that a change in designation may be made upon renewal of the policy with approval of the policyholder. With respect to the designated primary state, the issuer shall be licensed and approved to be doing business in that state;

(ii) In the case of a health insurance issuer that is selling a policy in, or to a resident of, a secondary state, the issuer shall be licensed and approved to be doing business in that secondary state; and

(iii) The covered laws of the primary state shall apply to individual health insurance coverage offered by a health insurance issuer in the primary state and policies sold in any secondary state. The coverage and issuer shall comply with these terms and conditions with respect to the offering of coverage in Wyoming.

(d) Except as provided in this section, a health insurance issuer with respect to its offer, sale, rating (including medical underwriting), benefit payment requirements, renewal and issuance of comprehensive individual medical and surgical health insurance coverage in Wyoming is exempt from any covered laws of Wyoming as the secondary state and any rules, regulations, agreements or orders sought or issued by the commissioner under or related to the covered laws to the extent that the laws would:

(i) Make unlawful or regulate, directly or indirectly, the operation of the health insurance issuer operating in Wyoming as a secondary state, except that the commissioner may require an issuer:

(A) To pay on a nondiscriminatory basis applicable premium and other taxes, including high risk pool assessments and other assessments which are levied on insurers and surplus lines insurers, brokers or policyholders under the laws of Wyoming;

(B) To register with and designate the commissioner as its agent solely for the purpose of receiving service of legal documents or process;

(C) To submit to examinations of its financial condition in accordance with the policies and regulations established through the national association of insurance commissioners for accreditation of states to perform these examinations;

(D) To comply with an injunction issued by a court of competent jurisdiction, upon a petition by the commissioner acting pursuant to chapters 28 of this code, chapter 48 of this code or W.S. 26-34-122 or 26-34-123;

(E) To participate, on a nondiscriminatory basis, in any insurance insolvency guaranty association or similar association to which a health insurance issuer in the state is required to belong;

(F) To comply with any state law regarding fraud and abuse, except that if the state seeks an injunction regarding the conduct described in this subparagraph, the injunction shall be obtained from a court of competent jurisdiction;

(G) To comply with any state law regarding unfair claims settlement practices; and

(H) To comply with the applicable requirements for external review procedures with respect to coverage offered in the state.

(ii) Discriminate against the issuer issuing insurance in both the primary state and in any secondary state.

(e) Nothing in this section shall be construed to prohibit a health insurance issuer:

(i) From terminating or discontinuing coverage or a class of coverage in accordance with the laws of the primary state;

(ii) From reinstating lapsed coverage; or

(iii) From retroactively adjusting the rates charged an insured individual if the initial rates were set based on

material misrepresentation by the individual at the time of issue.

(f) A health insurance issuer may not offer for sale individual health insurance coverage in Wyoming unless that coverage is currently offered for sale in the primary state.

(g) A person acting, or offering to act, as an agent or broker for a health insurance issuer with respect to the offering of individual health insurance coverage shall obtain a license from Wyoming, with commissions or other compensation subject to the provisions of the laws of Wyoming, except that Wyoming may not impose any qualification or requirement which discriminates against a nonresident agent or broker.

(h) Each health insurance issuer issuing individual health insurance coverage in both primary and secondary states shall submit to the insurance commissioner of each state in which it intends to offer the coverage before it may offer individual health insurance coverage in the state:

(i) A copy of the plan of operation or feasibility study or any similar statement of the policy being offered and its coverage which shall include the name of its primary state and its principal place of business;

(ii) Written notice of any change in its designation of its primary state; and

(iii) Written notice from the issuer of the issuer's compliance with all the laws of the primary state.

(j) Nothing in this section shall be construed to affect the authority of any federal or state court to enjoin the solicitation or sale of individual health insurance coverage by a health insurance issuer to any person or group who is not eligible for that insurance.

(k) Out-of-state companies offering health benefit plans under this article shall be subject to regulation by the commissioner with regard to enforcement of the contractual benefits under the health benefit plan, including the requirements regarding prompt payment of claims for benefits pursuant to W.S. 26-13-124 and 26-15-124.

26-18-206. Rules and regulations.

(a) The commissioner shall draft rules and regulations necessary to implement this article but shall be under no obligation to draft rules and regulations until after March 15, 2011. The commissioner may adopt the rules provided they are consistent with the requirements of W.S. 26-18-206.

(b) Any dispute resolution mechanism or provision for notice and hearing in this title shall apply to insurers issuing and delivering plans pursuant to this article.

26-18-207. Conflict with other code provisions.

If the provisions of this article conflict with any other provision of this code, the provisions of this article shall control.

26-18-208. Authorization date.

No policy shall be issued or delivered for issuance in this state pursuant to the provisions of this article before July 1, 2011.

ARTICLE 3 - SALE OF OUT-OF-STATE HEALTH INSURANCE POLICIES

26-18-301. Definitions.

(a) As used in this article:

(i) "Health insurance," "health benefit plan" and "health benefit policy" mean a health benefit plan as defined by W.S. 26-1-102(a)(xxxii);

(ii) "High deductible health plan" means health insurance plans sold or maintained under the applicable provisions of section 223 of the Internal Revenue Code;

(iii) "Small employer" means small employer as defined by W.S. 26-19-302(a)(xxii);

(iv) "Small employer health insurance policy" is any policy defined by W.S. 26-19-303(a).

26-18-302. Sale of health insurance policies approved in other states.

(a) The insurance commissioner shall approve for sale in Wyoming any individual or small employer health insurance policy

or high deductible health plan that is currently approved for issuance in another state where the insurer or the insurer's affiliate or subsidiary is authorized to transact insurance, subject to the following:

(i) Approval shall include approval of any relevant policy forms, provided the forms have been approved by the appropriate regulatory body in the other state;

(ii) The insurer or the insurer's affiliate or subsidiary filing and issuing the policy in Wyoming is also authorized to transact insurance in this state pursuant to title 26, chapter 3 of the Wyoming statutes;

(iii) The policy meets the requirements of this article;

(iv) The insurer shall agree that the Wyoming insurance commissioner may enforce the provisions of the insurance policy and resolve disputes between the insurer and the policyholder in the same manner as the regulatory authorities in the other state, provided that if a contested case arises it shall be subject to the provisions of the Wyoming Administrative Procedure Act and any appeals shall be resolved in Wyoming courts;

(v) The insurer shall inform the commissioner whether the policy will be priced as it is in the other state or at a Wyoming specific price;

(vi) For small employer health insurance policies, all policies shall be subject to the provisions of W.S. 26-19-306(a) and (c)(vi);

(vii) The commissioner shall review any provider network requirements in the policy and may require modification of those requirements if the insurer lacks sufficient within network providers in Wyoming;

(viii) Any authorized insurer may offer an individual or small employer an insurance policy with benefits equivalent to those in any policy approved for sale in Wyoming under this article provided that the offered policy meets the requirements of this article.

26-18-303. Financial requirements; continuing compliance.

(a) Any insurer selling a health insurance policy pursuant to this article and any policy approved pursuant to this article shall satisfy actuarial standards of the National Association of Insurance Commissioners, the requirements of this article and any regulations of the department implementing this article.

(b) The commissioner shall determine whether an insurer satisfies the requirements of this article and shall expeditiously approve policies and plans that comply with this article. The commissioner shall have the authority to determine whether a health insurance policy or plan sold pursuant to this article continues to satisfy the requirements of this article in the same manner as for other policies under this code. The commissioner shall have the authority to require an insurer to participate in the Wyoming health insurance pool and to make other payments required of insurers under this code.

(c) Any policy sold pursuant to this article shall be protected under the Wyoming Life and Health Guaranty Association Act under Chapter 42 of this title.

26-18-304. Disclaimers required.

(a) Each written application for a policy sold pursuant to this article shall contain the following language in boldface type at the beginning of the document:

Warning!

The benefits of this policy may primarily be governed by the laws of a state other than Wyoming. All of the laws applicable to policies filed in this state may not apply to this policy. Any purchase of individual health insurance should be considered carefully since future medical conditions may make it impossible to qualify for another individual health insurance policy.

(b) Each policy sold pursuant to this article shall contain the following language in boldface type at the beginning of the document:

Warning!

The benefits of this policy may be governed primarily by the laws of a state other than Wyoming. The benefits covered may be different from other policies you can purchase in this state. Consult your insurance agent or insurer to determine which health benefits are covered under this policy.

26-18-305. Rules and regulations.

(a) The commissioner shall adopt rules and regulations necessary to implement this article.

(b) Any dispute resolution mechanism or provision for notice and hearing in this code shall apply to insurers issuing and delivering policies pursuant to this article.

26-18-306. Conflict with other code provisions.

If the provisions of this article conflict with any other provision of this code, the provisions of this article shall control.

26-18-307. Authorization date.

No policy shall be issued or delivered for issuance in this state pursuant to this article before July 1, 2013.

CHAPTER 19 - GROUP AND BLANKET DISABILITY INSURANCE

ARTICLE 1 - IN GENERAL

26-19-101. Scope and applicability of article; short title.

(a) This article applies only to group disability and blanket disability insurance contracts.

(b) This article may be cited as the "Group and Blanket Disability Insurance Law".

(c) This article does not apply to any contract made or issued prior to January 1, 1968, nor to any extensions, renewals, reinstatements or modifications of or amendments to any contract whenever made.

26-19-102. "Group disability insurance" defined; eligible groups.

(a) "Group disability insurance" means that form of disability insurance covering groups of persons as described in this section and W.S. 26-19-110, with or without one (1) or more members of their families or one (1) or more of their dependents, or covering one (1) or more members of the families

or one (1) or more dependents of the groups of persons. Except as provided in W.S. 26-19-110, a group disability insurance policy shall not be issued for delivery in this state unless the policy is issued to:

(i) An employer or trustees of a fund established or adopted by an employer, which employer or trustee is deemed the policyholder, insuring the employer's employees for the benefit of persons other than the employer, subject to the following requirements:

(A) All employees or any class of employees are eligible for insurance under the terms of the policy;

(B) The policy may define "employees" to include:

(I) The officers, managers and employees of the employer;

(II) The individual proprietor or partner if the employer is an individual proprietor or partnership;

(III) The officers, managers and employees of subsidiary or affiliated corporations;

(IV) The individual proprietors, partners and employees of individuals and firms, if the business of the employer and the individual or firm is under common control through stock ownership, contract, or otherwise;

(V) Retired employees;

(VI) Former employees;

(VII) Directors of a corporate employer;

(VIII) Elected or appointed officials;

(IX) The trustees, their employees, or both, if their duties are principally connected with the trusteeship.

(C) If the insured employee does not pay any part of the premium for his insurance, the policy shall insure all eligible employees, except those who reject the coverage in writing.

(ii) An association, or a trust or the trustee of a fund established or adopted for the benefit of members of one (1) or more associations. The association shall have at the time the policy is first issued a minimum of fifty (50) persons eligible for insurance, shall have a constitution and bylaws which provide that the association holds regular meetings not less than annually to further the members' purposes, that the association, except for credit unions, collects dues or solicits contributions from members, and that the members have voting privileges and representation on the governing board and committees. Prior to marketing or offering any group disability insurance to an association formed for the sole purpose of obtaining insurance, the producer shall file a written report with the department setting forth the name of the association, the insurer and its address and the offering producer and his address. The department shall keep the name of the association confidential. The provisions of the Small Employer Health Insurance Availability Act, W.S. 26-19-301 et seq., shall apply to all insurance issued to an association under this section. As used in this paragraph, "association" shall not include a multiple employer welfare arrangement. The policy is subject to the following requirements:

(A) The policy may insure one (1) or more of the following or all of any class of the following for the benefit of persons other than the employee's employer:

(I) Members of the association;

(II) Employees of the association; or

(III) Employees of members.

(B) If the covered person does not pay any part of the premium for his insurance, the policy shall insure all eligible persons, except those who reject the coverage in writing.

(iii) A trust or the trustees of a fund established or adopted by two (2) or more employers, by one (1) or more labor unions or similar employee organizations, or by one (1) or more employers and one (1) or more labor unions or similar employee organizations, which trust or trustees are deemed the policyholder, to insure employees of the employers or members of the union or organization for the benefit of persons other than

the employers, unions or organizations, subject to the following requirements:

(A) All employees of the employers, members of the unions or organizations or any class of the employers, union members or organization members are eligible for insurance under the terms of the policy;

(B) The policy may provide that the term "employees" shall include:

(I) The employees of one (1) or more subsidiary corporations and the employees, individual proprietors and partners of one (1) or more affiliated corporations, proprietorships or partnerships if the business of the employer and of the affiliated corporations, proprietorships or partnerships is under common control;

(II) Retired or former employees;

(III) Directors of a corporate employer;

(IV) The trustees, trustees' employees, or both, if their duties are principally connected with the trusteeship.

(C) If the insured person does not pay any part of the premium for his insurance, the policy shall insure all eligible persons, except those who reject such coverage in writing.

(iv) Under a policy issued to any person or organization to which a policy of group life insurance may be issued or delivered in this state to insure any class or classes of individuals that could be insured under the group life policy;

(v) Repealed by Laws 1990, ch. 5, § 3.

(vi) A creditor, a creditor's parent holding company or a trustee or agent designated by two (2) or more creditors, which creditor, holding company, affiliate, trustee or agent is deemed the policyholder, to insure debtors of the creditor concerning their indebtedness, subject to the following requirements:

(A) All debtors or any class of debtors of the creditor are eligible for insurance under the terms of the policy;

(B) The policy may provide that the term "debtors" shall include:

(I) Borrowers of money or purchasers or lessees of goods, services or property for which payment is arranged through a credit transaction;

(II) The debtors of one (1) or more subsidiary corporations; and

(III) The debtors of one (1) or more affiliated corporations, proprietorships or partnerships if the business of the policyholder and of the affiliated corporations, proprietorships or partnerships is under common control.

(C) If the insured debtor does not pay any part of the premium for his insurance, the policy shall insure all eligible debtors;

(D) The total amount of insurance payable for an indebtedness shall not exceed the greater of the scheduled or actual amount of unpaid indebtedness to the creditor. The insurer may exclude any payments which are delinquent on the date the debtor is disabled as defined in the policy;

(E) The insurance may be payable to the creditor or any successor to the right, title and interest of the creditor. The payment shall reduce or extinguish the unpaid indebtedness of the debtor to the extent of the payment and any excess of the insurance is payable to the insured or the estate of the insured;

(F) Notwithstanding subparagraphs (A) through (D) of this paragraph, insurance on agricultural credit transaction commitments may be written up to the amount of the loan commitment. Insurance on educational credit transaction commitments may be written up to the amount of the loan commitment less the amount of any repayments made on the loan.

(vii) A credit union or a trustee or agent designated by two (2) or more credit unions, which credit union, trustee or agent is deemed the policyholder, to insure members of the credit union for the benefit of persons other than the credit

union, trustee, agent or any of their officials, subject to the following requirements:

(A) All members or all of any class of members of the credit union are eligible for insurance under the terms of the policy;

(B) Policy premiums shall be paid by the policyholder from the credit union's funds and shall insure all eligible members.

(viii) A labor union or similar employee organization which union or organization is deemed the policyholder, to insure members of the union or organization for the benefit of persons other than the union or organization or any of its officials, representatives or agents, subject to the following requirements:

(A) All members or any class of members of the union or organization are eligible for insurance under the terms of the policy;

(B) If the insured member does not pay any part of the premium for his insurance, the policy shall insure all eligible members, except those who reject such coverage in writing.

(ix) A multiple employer welfare arrangement under the jurisdiction of the department which:

(A) Is domiciled in Wyoming; or

(B) Maintains its principal place of business in Wyoming.

26-19-103. Repealed by Laws 1990, ch. 5, § 3.

26-19-104. Repealed by Laws 1990, ch. 5, § 3.

26-19-105. Readjustment of premiums; dividends.

Any group disability insurance contract may provide for the readjustment of the rate of premium based upon the experience under the contract. If a policy dividend is declared or a reduction in rate is made or continued for the first or any subsequent year of insurance under any group disability insurance policy issued to any policyholder, the excess, if any,

of the aggregate dividends or rate reductions under the policy and all other group insurance policies of the policyholder over the aggregate expenditure for insurance under those policies made from funds contributed by the policyholder, or by an employer of insured persons, or by a union or association to which the insured persons belong, including expenditures made in connection with administration of the policies, shall be applied by the policyholder for the sole benefit of insured employees or members.

26-19-106. Blanket disability insurance; defined.

(a) Blanket disability insurance is that form of disability insurance covering groups of persons under a policy or contract issued to:

(i) Any common carrier or to any operator, owner or lessee of a means of transportation, who is deemed the policyholder, covering a group of persons who may become passengers as defined by reference to their travel status on the common carrier or the means of transportation;

(ii) An employer, who is deemed the policyholder, covering any group of employees, dependents or guests, defined by reference to specified hazards incident to an activity or activities or operations of the policyholder;

(iii) A college, school or other institution of learning, a school district or school jurisdictional unit, or to the head, principal or governing board of any educational unit, who is deemed the policyholder, covering students, teachers or employees;

(iv) Any religious, charitable, recreational, educational or civic organization, or branch thereof, which is deemed the policyholder, covering any group of members or participants defined by reference to specified hazards incident to an activity or operations sponsored or supervised by the policyholder;

(v) A sports team, camp or sponsor thereof, which is deemed the policyholder, covering members, campers, employees, officials or supervisors;

(vi) Any volunteer fire department, first aid, civil defense or other similar volunteer organization, which is deemed the policyholder, covering any group of members or participants

defined by reference to specified hazards incident to an activity or operations sponsored or supervised by the policyholder;

(vii) A newspaper or other publisher, which is deemed the policyholder, covering its carriers;

(viii) An association, including a labor union, which has a constitution and bylaws and which is deemed the policyholder, covering any group of members or participants defined by reference to specified hazards incident to an activity or operations sponsored or supervised by the policyholder. Prior to marketing or offering any blanket disability insurance to an association, including a labor union, formed for the sole purpose of obtaining insurance, the producer shall file a written report with the department setting forth the name of the association, the insurer and its address and the offering producer and his address. The department shall keep the name of the association confidential. The provisions of the Small Employer Health Insurance Availability Act, W.S. 26-19-301 et seq., shall apply to all insurance issued to an association under this section. As used in this paragraph, "association" shall not include a multiple employer welfare arrangement;

(ix) Cover any other risk or class of risks which, in the commissioner's discretion, may be properly eligible for blanket disability insurance. The commissioner's discretion may be exercised on an individual risk basis or class of risks, or both.

26-19-107. Group disability and blanket insurance standard provisions; exceptions.

(a) A policy of group disability or blanket disability insurance shall not be delivered in this state unless it contains in substance the following provisions or provisions which in the commissioner's opinion are more favorable to the persons insured or at least as favorable to the persons insured and more favorable to the policyholder:

(i) The policy, including endorsements and a copy of the application, if any, of the policyholder and the persons insured constitutes the entire contract between the parties;

(ii) Written notice of a claim shall be given to the insurer within twenty (20) days after the occurrence or commencement of any loss covered by the policy. Failure to give

notice within the time provided by this paragraph shall not invalidate nor reduce any claim if it is shown it was not reasonably possible to give notice and that notice was given as soon as was reasonably possible;

(iii) The insurer shall furnish either to the person making a claim or to the policyholder for delivery to the person making a claim the forms it usually furnishes for filing proof of loss. If the forms are not furnished before the expiration of fifteen (15) days after giving of the notice specified in paragraph (ii) of this subsection, the person making the claim is 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, the character and the extent of the loss for which claim is made;

(iv) In the case of claim for loss of time for disability, written proof of the loss shall be furnished to the insurer within ninety (90) days after the commencement of the period for which the insurer is liable. Subsequent written proofs of the continuance of the disability shall be furnished to the insurer at any intervals the insurer reasonably requires. In the case of claim for any other loss, written proof of the loss shall be furnished to the insurer within ninety (90) days after the date of the loss. Failure to furnish proof within the time provided by this paragraph shall not invalidate nor reduce any claim if it is shown it was not reasonably possible to furnish proof and that proof was furnished as soon as was reasonably possible;

(v) Any benefits payable under the policy are payable as follows:

(A) Benefits other than benefits for loss of time are payable not more than forty-five (45) days after receipt of written proof of the loss and supporting evidence;

(B) Subject to proof of loss and supporting evidence, all accrued benefits payable under a policy for loss of time are payable not less frequently than monthly during the continuance of the disability period for which the insurer is liable, and any balance remaining unpaid at the termination of the disability period is payable immediately upon receipt of proof and supporting evidence.

(vi) The insurer, at its own expense, may:

(A) Examine the person of the insured when and as often as it reasonably requires during the pendency of claim under the policy; and

(B) Make an autopsy if it is not prohibited by law.

(vii) No action at law or in equity shall be brought to recover under the policy prior to the expiration of sixty (60) days after written proof of loss is furnished in accordance with the requirements of the policy and no action shall be brought upon the expiration of three (3) years after the time written proof of loss is required to be furnished;

(viii) The policyholder is entitled to a grace period of thirty-one (31) days for the payment of any premium due except the first, and during the grace period the policy shall continue in force unless the policyholder gave 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 is liable to the insurer for the payment of a pro rata premium for the time the policy was in force during the grace period provided by this paragraph;

(ix) The validity of the policy shall not be contested except for nonpayment of premiums after it has been in force for two (2) years from the date of issue, and no statement made by any person covered under the policy relating to insurability shall be used in contesting the validity of the insurance with respect to which the statement was made after the insurance has been in force prior to the contest for a period of two (2) years during the person's lifetime unless the statement is contained in a written instrument signed by the person making the statement;

(x) A copy of the application, if any, of the policyholder shall be attached to the policy when issued. All statements made by the policyholder or by the persons insured are deemed representations and not warranties. 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 the person or, in the event of the death or incapacity of the insured person, to the individual's beneficiary or personal representative;

(xi) The additional exclusions or limitations, if any, applicable under the policy concerning 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 shall be specified. The exclusion or limitation shall not exclude coverage for a period beyond twelve (12) months following the individual's effective date of coverage and shall only relate to conditions for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage. In determining whether a preexisting condition provision applies to an insured or dependent, all private or public health benefit plans shall credit the time the person was previously covered by a private or public health benefit plan if the previous coverage was continuous to a date not more than ninety (90) days prior to the effective date of the new coverage exclusive of any applicable waiting period. In the case of a preexisting conditions limitation allowable in the succeeding carrier's plan, the level of benefits applicable to preexisting conditions of persons becoming covered by the succeeding carrier's plan during the period of time this limitation applies under the new plan shall be the lesser of:

(A) The benefits of the new plan determined without application of the preexisting conditions limitation; or

(B) The benefits of the prior plan.

(xii) If the premiums or benefits vary by age, a provision shall specify an equitable adjustment of premiums, benefits, or both, to be made if the age of a covered person has been misstated and containing a clear statement of the method of adjustment to be used;

(xiii) The insurer shall issue to the policyholder for delivery to each person insured a certificate containing a statement of the insurance protection to which that person is entitled, to whom the insurance benefits are payable and of any family member's or dependent's coverage;

(xiv) Benefits for loss of life of the person insured are payable to the beneficiary designated by the person insured or if the policy contains conditions pertaining to family status the beneficiary may be the family member specified by the policy terms. Payment of benefits for loss of life of the person

insured is subject to the provisions of the policy in the event no designated or specified beneficiary is living at the death of the person insured. All other benefits of the policy are payable to the person insured. The policy may 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 the benefit, up to an amount not exceeding five thousand dollars ($5,000.00), to any relative by blood, marriage or adoption of the person deemed by the insurer to be equitably entitled to the benefits;

(xv) For a policy insuring debtors, the insurer shall furnish the policyholder for delivery to each debtor insured under the policy a certificate of insurance describing the coverage and specifying that the benefits payable shall first be applied to reduce or extinguish the indebtedness;

(xvi) Repealed By Laws 1997, ch. 120, § 2.

(xvii) Repealed by Laws 2025, ch. 114, § 2.

(b) W.S. 26-19-107(a)(xi), (xiii) and (xiv) shall not apply to policies insuring debtors.

(c) The standard provisions for individual disability insurance policies shall not apply to group disability insurance policies.

(d) If any provision of this section is entirely or partially inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer with the approval of the commissioner shall omit from the policy any inapplicable provision or part of a provision and shall modify any inconsistent provision or part of the provision to conform the policy provision with the coverage provided by the policy.

(e) Repealed By Laws 1997, ch. 120, § 2.

(f) No policy of group or blanket disability insurance shall treat the following as a preexisting condition:

(i) Pregnancy existing on the effective date of coverage;

(ii) Genetic information, in the absence of a diagnosis of a condition related to the genetic information.

(g) A policy of group or blanket disability insurance shall not establish rules for eligibility, including continued eligibility, of any individual to enroll under the policy based on any of the following health status related factors in relation to the employee or an eligible dependent:

(i) Health status;

(ii) Medical condition, including both physical and mental illness;

(iii) Claims experience;

(iv) Receipt of health care;

(v) Medical history;

(vi) Genetic information;

(vii) Evidence of insurability, including conditions arising out of acts of domestic violence;

(viii) Disability.

(h) Repealed by Laws 2025, ch. 114, § 2.

(j) All group and blanket disability insurance policies providing coverage on an expense incurred basis, group service or indemnity type contracts issued by a nonprofit corporation, group service contracts issued by a health maintenance organization, all self-insured group arrangements to the extent not preempted by federal law and all managed health care delivery entities of any type or description, that are delivered, issued for delivery, continued or renewed on or after July 1, 2001, and providing coverage to any resident of this state shall provide benefits or coverage for:

(i) A pelvic examination and pap smear for any nonsymptomatic women covered under the policy or contract;

(ii) A colorectal cancer examination and laboratory tests for cancer for any nonsymptomatic person covered under the policy or contract;

(iii) A prostate examination and laboratory tests for cancer for any nonsymptomatic man covered under the policy or contract; and

(iv) A breast cancer examination including a screening mammogram and clinical breast examination for any nonsymptomatic person covered under the policy or contract.

(k) To encourage public health and diagnostic health screenings, the services covered under subsection (j) of this section shall be provided with no deductible due and payable. A health plan shall, at a minimum, be liable for eighty percent (80%) of the reimbursement allowance of the health plan up to a maximum of two hundred fifty dollars ($250.00) per adult insured per year. A patient shall be liable for coinsurance up to twenty percent (20%) if such coinsurance is required pursuant to the patient's health care coverage. Coverage may be in addition to any other preventive care services. This subsection shall apply to private health benefit plans as defined by W.S. 26-1-102(a)(xxxiii) except that it shall not apply to high deductible policies where the deductible equals or exceeds one thousand dollars ($1,000.00) per person or per family per year or policies qualifying as federal medical savings accounts.

(m) In addition to the prohibitions on the use of genetic information provided in paragraph (g)(vi) of this section, an insurer offering a policy of group or blanket disability insurance shall not, based on the genetic testing information of an individual or a family member of an individual:

(i) Deny eligibility;

(ii) Adjust premium rates;

(iii) Adjust contribution rates;

(iv) Request or require predictive genetic testing information concerning an individual or a family member of the individual, except the insurer may request, but not require, predictive genetic testing information if needed for diagnosis, treatment or payment. As part of a request under this paragraph, the plan or issuer shall provide a description of the procedures in place to safeguard confidentiality of the information.

26-19-108. Group disability and blanket insurance standard provisions; application and certificate need not be furnished.

An individual application need not be required from a person covered under a blanket disability policy or contract, nor is it necessary for the insurer to furnish each person a certificate.

26-19-109. To whom benefits are payable.

(a) Any benefits under any group or blanket disability policy or contract are payable to the person insured, or to his designated beneficiary or beneficiaries, or to his estate, except that if the person insured is a minor or otherwise not competent to give a valid release, the benefits may be made payable to his parent, guardian or other person actually supporting him. The policy may provide that any indemnities provided by the policy because of hospital, nursing, medical or surgical services, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of loss, may be paid directly to the hospital or person rendering the services. The policy may not require that the service be rendered by a particular hospital or person. Any payment made under the policy discharges the insurer's obligation with respect to the amount of insurance so paid.

(b) Any group disability policy which contains provisions for the insurer to pay benefits for expenses incurred for hospital, nursing, medical or surgical services for members of the family or dependents of a person insured may provide for the continuation of the benefit provisions entirely or partially after the death of the person insured.

26-19-110. Additional disability insurance groups; requirements.

(a) Group disability insurance offered to a resident under a group disability insurance policy issued to a group other than one described in W.S. 26-19-102 is subject to the following requirements:

(i) A group disability insurance policy shall not be delivered in this state unless the commissioner finds that:

(A) The issuance of the group policy is not contrary to the best interest of the public;

(B) The issuance of the group policy would result in economies of acquisition or administration;

(C) The benefits are reasonable in relation to the premiums charged;

(D) The insurer possesses and maintains capital and surplus requirements provided by W.S. 26-3-108 and reserve requirements provided by W.S. 26-6-107.

(ii) Group disability insurance coverage shall not be offered in this state by an insurer under a policy issued in another state unless the commissioner determines the requirements of paragraph (i) of this subsection are met and the insurer files with the commissioner:

(A) A copy of the group master contract;

(B) A copy of the statute of the state where the group policy is issued that authorizes the issuance of the group policy;

(C) Evidence of approval of the group policy in the state where the group policy is issued; and

(D) Copies of all supportive material used by the insurer to secure approval of the group in the state where the group policy is issued.

(iii) If the commissioner fails to make the determination provided by paragraph (ii) of this subsection within forty-five (45) days of filing by the insurer of the documents required by paragraph (ii) of this subsection, the requirements of paragraph (i) of this subsection are deemed to be met.

26-19-111. Notice of compensation.

(a) The insurer shall distribute to prospective insureds a written notice that compensation shall or may be paid for a program of group insurance which would qualify under W.S. 26-19-102(a)(ii) or 26-19-110, if compensation of any kind shall or may be paid to:

(i) A policyholder or sponsoring or endorsing entity in the case of group policy; or

(ii) A sponsoring or endorsing entity in the case of individual, blanket or franchise policies marketed by means of direct response solicitation.

(b) Notice required by this section shall be distributed:

(i) Whether compensation is direct or indirect; and

(ii) Whether compensation is:

(A) Paid to or retained by the policyholder or sponsoring or endorsing entity; or

(B) Paid to or retained by a third party at the direction of the policyholder, sponsoring or endorsing entity or an entity affiliated by way of ownership, contract or employment.

(c) The notice required by this section shall be placed on or accompany any application or enrollment form provided to prospective insureds.

(d) As used in this section:

(i) "Direct response solicitation" means a solicitation through a sponsoring or endorsing entity by the mails, telephone or other mass communications media; and

(ii) "Sponsoring or endorsing entity" means an organization which has arranged for the offering of a program of insurance in a manner which communicates that eligibility for participation in the program is dependent upon affiliation with the organization or that it encourages participation in the program.

26-19-112. Dependent group disability insurance.

Except for a policy issued under W.S. 26-19-102(a)(vi), a group disability insurance policy may be extended to insure the employees' or members' or any class of employees' or members' family members or dependents. If the employee or member does not pay any part of the premium for the family members or dependents coverage, the policy shall insure all eligible employees, members or any class of employees or members.

26-19-113. Continuation of group coverage after termination of employment or membership.

(a) A non-COBRA group policy or certificate of insurance on a master policy of a group delivered or issued for delivery in this state on or after July 1, 1995, issued by any insurance company, nonprofit health service corporation, health maintenance organization or any other insurer that provides

hospital, surgical or major medical expense insurance or any accommodation of these coverages on an expense incurred basis, but not a policy that provides benefits for specific diseases or for accidental injuries only, shall provide that employees, members or their covered eligible dependents whose insurance under the group policy would otherwise terminate because of termination of employment or membership or eligibility for coverage are entitled to continue their hospital, surgical and major medical insurance under that group policy, for themselves, their eligible dependents or both, subject to all of the group policy's terms and conditions applicable to those forms of insurance and to the following conditions:

(i) Continuation is only 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 (3) month period ending with the termination of eligibility;

(ii) Continuation is not available for any person who is:

(A) Covered by medicare, excluding his spouse or dependent children who shall be entitled to continuation; or

(B) Covered by any other insured or uninsured arrangement which provides hospital, surgical or medical coverage for individuals in a group.

(iii) Continuation need not include dental or vision care benefits or any other benefits provided under the group policy in addition to its hospital, surgical or major medical benefits unless the insurer previously included such benefits and the insured requests such benefits;

(iv) An employee or member who wishes continuation of coverage shall request the continuation in writing within the thirty-one (31) day period following the date of termination of coverage;

(v) An employee or member electing continuation shall pay to the insurer, third party administrator, group policyholder or the employer, as designated by the employer, on a monthly basis in advance, the amount of contribution required by the policyholder or employer, but not more than one hundred two percent (102%) of the group rate for the insurance being continued under the group policy on the due date of each

payment. The employer's designation with regard to whom the electing employee or member shall pay his contribution shall be made in writing prior to the date the first contribution by the employee or member is due. 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, shall be given to the insurer, third party administrator, policyholder or employer within thirty-one (31) days of the date the employee's or member's insurance would otherwise terminate;

(vi) Continuation of insurance under the group policy for any person terminates when the person fails to satisfy paragraph (ii) of this subsection or, if earlier, at the first to occur of the following:

(A) The date twelve (12) months 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 the employer terminates participation under the group policy. However, if this subparagraph applies and the coverage ceasing by reason of the termination is replaced by similar coverage under another group policy, the following apply:

(I) The employee or member may become covered under that other group policy for the balance of the period that the employee or member would have remained covered under the prior group policy in accordance with this paragraph had a termination described in this subparagraph not occurred;

(II) The minimum level of benefits to be provided by the other group policy is the applicable level of benefits of the prior group policy reduced by any benefits payable under that prior group policy;

(III) 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.

(vii) A notification of the continuation privilege shall be included in each certificate of coverage;

(viii) Upon termination of the continuation period, the member, surviving spouse or dependent is 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 the election and pay the required premium within thirty-one (31) days of the termination of the continued coverage under the group contract.

(b) As used in subsection (a) of this section, "non-COBRA" means any group policy or certificate of insurance on a master policy of a group policy which is not subject to continuation of rights as provided under the federal Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

26-19-114. Failure to pay premiums; notification.

When an employer or trustee of a fund established or adopted by an employer, which employer or trustee is deemed the policyholder of the group disability insurance policy insuring the employer's employees for the benefit of persons other than the employer and where the employer or trustee routinely pays any part of the premium for the policy, if the employer or trustee fails to pay the routinely paid portion of the premium when required under the policy for any reason, the employer or trustee shall notify the employee or beneficiary, electronically or in writing, within thirty (30) days of the failure to pay.

26-19-115. Multiple employer welfare arrangements; required license; applicability of the Small Employer Health Insurance Availability Act; hearings; rules.

(a) A multiple employer welfare arrangement, as defined in W.S. 26-1-102(a)(xliii), intending to operate in Wyoming shall provide to the department all necessary documents to facilitate a determination of jurisdiction under W.S. 26-1-108. The department may specify required documents under this subsection by rule.

(b) Before operating in this state, a multiple employer welfare arrangement subject to the jurisdiction of the department shall obtain an annual license. The department shall collect a fee for each license or renewal, as provided in W.S. 26-4-101(a)(xx).

(c) Except as otherwise provided in this subsection, the provisions of the Small Employer Health Insurance Availability Act, W.S. 26-19-301 through 26-19-310, shall apply to multiple employer welfare arrangements subject to the jurisdiction of the department, including arrangements providing benefits to one (1) or more employees of a small employer, as defined in W.S. 26-19-302(a)(xxii). The provisions of W.S. 26-19-303(a) shall not apply.

(d) The provisions of chapter 20 of this title shall apply to those multiple employer welfare arrangements subject to the jurisdiction of the department.

(e) The commissioner may suspend, revoke or refuse to issue or renew a license required by subsection (b) of this section, consistent with the Wyoming Administrative Procedure Act, W.S. 16-3-101 through 16-3-115 and 26-2-125 through 26-2-129.

(f) The commissioner may adopt rules to implement this section, including specifying the conditions under which actions may be taken under subsection (e) of this section, which shall be consistent with other insurance statutes governing suspensions, revocations or refusals to issue or renew licenses.

ARTICLE 2 - GROUP COVERAGE REPLACEMENT ACT

26-19-201. Purpose and scope of article.

(a) The purpose of this article is to:

(i) Provide for continuance of coverage for all participants when a succeeding carrier's contract replaces a prior plan's benefits; and

(ii) Prohibit the imposition of preexisting condition limitations under certain circumstances.

(b) This article is applicable to all insurance policies and subscriber contracts issued or provided by an insurance company or a nonprofit service corporation on a group or group-type basis covering persons as employees of employers or as members of unions, associations, multiple employer trusts or organizations, or any arrangement subject to the jurisdiction of the insurance department.

26-19-202. Definitions.

(a) As used in this article:

(i) "Carrier" means an insurance company, nonprofit service corporation, trust, association or other arrangement subject to the jurisdiction of the insurance department;

(ii) "Group-type basis" means a benefit plan which meets the following conditions:

(A) Coverage is provided through insurance policies or subscriber contracts to classes of employees or members defined in terms of conditions pertaining to employment or membership or any other arrangement subject to the jurisdiction of the insurance department;

(B) The coverage is not available to the general public and can be obtained and maintained only because of the covered person's membership in connection with the particular organization or group;

(C) There are arrangements for bulk payment of premiums or subscription charges to the insurer, nonprofit service corporation, association or trust;

(D) There is sponsorship of the plan by the employer, union, association, trust or organization; and

(E) Individually underwritten and issued guaranteed renewable policies shall not be considered "group-type basis" under this paragraph even though purchased through payroll deduction.

26-19-203. Continuance of coverage where one carrier's contract replaces a plan of similar benefits of another carrier.

(a) In those instances in which one (1) carrier's contract replaces a plan of similar benefits of another carrier:

(i) The prior carrier remains liable only to the extent of its accrued liabilities and extensions of benefits. The position of the prior carrier shall be the same whether the group policy holder or other entity secures replacement coverage from a new carrier, self-insures or foregoes the provision of coverage;

(ii) The succeeding carrier is liable under the following circumstances:

(A) Each person covered under the prior carrier's plan shall be eligible for complete coverage in accordance with the succeeding carrier's plan of benefits, which shall include coverage for ninety (90) days for any complication caused as a result of a condition for which benefits were paid under the prior plan within ninety (90) days prior to termination of that plan. Copayment and deductible levels for coverage required under this subparagraph may be applied in a manner consistent with those provided by the succeeding carrier's plan;

(B) In the case of a preexisting conditions limitation included in the succeeding carrier's plan, the level of benefits applicable to preexisting conditions of persons becoming covered by the succeeding carrier's plan in accordance with this paragraph during the period of time this limitation applies under the new plan shall be the lesser of:

(I) The benefits of the new plan determined without application of the preexisting conditions limitations; or

(II) The benefits of the prior plan.

(C) In any situation where a determination of the prior carrier's benefit is required by the succeeding carrier, at the succeeding carrier's request the prior carrier shall furnish a statement of the benefits available or pertinent information, sufficient to permit verification of the benefit determination or the determination itself by the succeeding carrier. For the purposes of this section, benefits of the prior plan will be determined in accordance with all of the definitions, conditions and covered expense provisions of the prior plan rather than those of the succeeding plan. The benefit determination will be made as if coverage had not been replaced by the succeeding carrier.

26-19-204. Violations; penalty.

Any person who violates any of the provisions of this article shall be subject to the penalties provided by W.S. 26-1-107.

ARTICLE 3 - SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY

26-19-301. Short title.

This act shall be known and may be cited as the "Small Employer Health Insurance Availability Act."

26-19-302. Definitions.

(a) As used in this act:

(i) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the commissioner that a small employer carrier is in compliance with the provisions of W.S. 26-19-304, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans;

(ii) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business, by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage;

(iii) "Basic health benefit plan" means a low cost health benefit plan developed pursuant to W.S. 26-19-308;

(iv) "Board" means the board of directors of the program;

(v) "Carrier" means any person who provides any health benefit plan in this state subject to state insurance regulation and includes, but is not limited to, an insurance company, a fraternal benefit society, a prepaid hospital or medical care plan, a health maintenance organization and a multiple employer welfare arrangement. For purposes of this act, companies that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as one (1) carrier except that any insurance company, health service corporation, hospital service corporation or medical service corporation that is an affiliate of a health maintenance organization located in this state, or any health maintenance organization located in this state which is an affiliate of an insurance company, health service corporation, hospital service corporation or medical service corporation may treat the health maintenance organization as a separate carrier and each health

maintenance organization that operates only one (1) health maintenance organization in an established geographic service area of this state may be considered a separate carrier;

(vi) "Case characteristics" means demographic or other objective characteristics of a small employer, as determined by a small employer carrier, that are considered by the small employer carrier in the determination of premium rates for the small employer, provided, however, that claim experience, health status and duration of coverage since issue are not case characteristics for the purposes of this act;

(vii) "Class of business" means all of a distinct grouping of small employers as shown on the records of the small employer carrier, and provided:

(A) A distinct grouping may only be established by the small employer carrier on the basis that the applicable health benefit plans:

(I) Are marketed and sold through individuals and organizations which are not participating in the marketing or sale of other distinct groupings of small employers for such small employer carrier;

(II) Have been acquired from another small employer carrier as a distinct grouping of plans; or

(III) Are provided through an association with membership of not less than two (2) small employers.

(B) A small employer carrier may establish no more than two (2) additional groupings under each subdivision (I) through (III) of subparagraph (A) of this paragraph on the basis of underwriting criteria which are expected to produce substantial variation in the health care costs;

(C) The commissioner may approve the establishment of additional distinct groupings upon application to the commissioner and a finding by the commissioner that such action would enhance the efficiency and fairness of the small employer marketplace.

(viii) Repealed by Laws 1995, ch. 94, § 3.

(ix) "Dependent" means:

(A) A spouse or unmarried child under the age of nineteen (19) years;

(B) An unmarried child who is a full-time student under the age of twenty-three (23);

(C) A child of any age who is disabled and dependent upon the parent;

(D) Any other individual defined to be a dependent in the health benefit plan covering the employee.

(x) "Eligible employee" means an employee who works on a full-time basis, with a normal work week of thirty (30) or more hours and has met any applicable waiting period requirements. The term includes a sole proprietor, a partner of a partnership or an independent contractor, if the sole proprietor, partner or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include employees who work on a part-time, temporary, seasonal or substitute basis;

(xi) "Established geographic service area" means a geographical area approved by the commissioner in conjunction with the carrier's certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage;

(xii) "Health benefit plan" means any hospital or medical policy or certificate, major medical expense insurance, hospital or medical service plan contract or health maintenance organization subscriber contract. "Health benefit plan" does not include accident-only, credit, dental, vision, Medicare supplement, long-term care or disability income insurance, coverage issued as a supplement to liability insurance, worker's compensation or similar insurance or automobile medical-payment insurance, nor does it include policies or certificates of specified disease, hospital confinement indemnity or limited benefit health insurance if the carrier offering the policies or certificates certifies to the commissioner that policies or certificates described in this paragraph are being offered and marketed as supplemental health insurance and not as a substitute for hospital or medical expense insurance or major medical expense insurance;

(xiii) Repealed by Laws 1993, ch. 83, § 2.

(xiv) "Index rate" means, for each class of business as to a rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate;

(xv) "Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period provided under the terms of the health benefit plan, provided that the initial enrollment period shall be a period of at least thirty (30) days. An eligible employee or dependent shall not be considered a late enrollee if:

(A) The individual:

(I) Was covered under a public or private health insurance or other health benefit arrangement at the time the individual was eligible to enroll;

(II) Has lost coverage under a public or private health insurance or other health benefit arrangement as a result of termination of employment or eligibility, the termination of the other plan's coverage, death of a spouse, divorce, legal separation or termination of employer contribution; and

(III) Requests enrollment within thirty (30) days after termination of coverage provided under a public or private health insurance or other health benefit arrangement.

(B) The individual is employed by an employer which offers multiple health benefit plans and the individual elects a different plan during an open enrollment period; or

(C) A court has ordered coverage be provided for a spouse or minor child under a covered employee's health benefit plan and request for enrollment is made within thirty (30) days after issuance of the court order.

(xvi) "New business premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or offered, or which could have been charged or offered, by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage;

(xvii) "Participating carrier" means all small employer carriers issuing health benefit plans in this state. "Participating carrier" shall also include any carrier that maintains an existing health benefit plan covering eligible employees of one (1) or more small employers;

(xviii) "Plan of operation" means the plan of operation of the program, including articles, bylaws and operating rules adopted by the board pursuant to W.S. 26-19-307;

(xix) "Preexisting condition provision" means a policy provision that excludes coverage for charges or expenses incurred during a specified period following the insured's effective date of coverage, as to a condition which, during a specified period immediately preceding the effective date of coverage, medical advice, diagnosis, care or treatment was recommended or received;

(xx) "Program" means the Wyoming small employer health reinsurance program created by W.S. 26-19-307;

(xxi) "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect, as determined by the small employer carrier;

(xxii) "Small employer" means any person, firm, corporation, partnership or association who is actively engaged in business who, on at least fifty percent (50%) of its working days during the preceding calendar quarter, employed at least two (2) but no more than fifty (50) eligible employees, the majority of whom were employed within this state or were residents of Wyoming. In determining the number of eligible employees, companies which are affiliated companies, or which are eligible to file a combined tax return for purposes of any state taxation, shall be considered one (1) employer;

(xxiii) "Small employer carrier" means any carrier that offers health benefit plans covering eligible employees of one (1) or more small employers;

(xxiv) "Standard health benefit plan" means a health benefit plan developed pursuant to W.S. 26-19-308;

(xxv) "Taft-Hartley trust" means a trust formed pursuant to a collective bargaining agreement under the federal Labor Management Relations Act of 1947;

(xxvi) "Affiliation period" means a period which, under the terms of the health insurance coverage offered by a health maintenance organization, must expire before the health insurance coverage becomes effective. The health maintenance organization is not required to provide health care services or benefits during an affiliation period and no premiums shall be charged to the participant or beneficiary for any coverage during the period;

(xxvii) "Provider network" means health insurance coverage offered by a health insurance issuer under which the financing and delivery of medical care, including items and services paid for as medical care, is provided in whole or in part, through a defined set of providers under contract with the issuer;

(xxviii) "This act" means W.S. 26-19-301 through 26-19-310.

26-19-303. Applicability and scope.

(a) This act shall apply to any health benefit plan which provides coverage to two (2) or more employees of a small employer in this state if:

(i) Any portion of the premium or benefits is paid by a small employer or if an eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by a small employer for any portion of the premium; or

(ii) The health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of section 162, section 125 or section 106 existing as of the effective date of this act or similar sections subsequently enacted of the United States Internal Revenue Code.

(b) Notwithstanding subsection (a) of this section, W.S. 26-19-305(a) and (c) and 26-19-304(a) shall not apply to individual health benefit policies sold to small employers which are subject to approval for policy form by the commissioner.

(c) A Taft-Hartley trust, or a carrier with the written authorization of a Taft-Hartley trust may make a written request to the commissioner for a waiver from the application of any of the provisions of W.S. 26-19-304(a) with respect to a health

benefit plan provided to the trust. The commissioner may grant the waiver if he finds that application of W.S. 26-19-304(a) with respect to the trust would have a substantial adverse effect on the participants and beneficiaries of the trust, and would require significant modifications to one (1) or more collectively bargained arrangement for which the trust is established or maintained. A waiver granted under this subsection shall not apply to an individual if the person participates in the trust as an associate member of an employee organization.

(d) This act shall apply to multiple employer welfare arrangements, consistent with W.S. 26-19-115.

26-19-304. Restrictions relating to premium rates.

(a) Premium rates for health benefit plans subject to this act shall be subject to the following provisions:

(i) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twenty percent (20%);

(ii) For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates which could be charged to employers under the rating system for that class of business shall not vary from the index rate by more than thirty-five percent (35%) of the index rate;

(iii) The percentage increase in the premium rate charged to a small employer for a new rating period shall not exceed the sum of the following:

(A) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which a small employer carrier is no longer enrolling new small employers, the carrier shall use the percentage change in the base premium rate, provided that the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the carrier is actively enrolling new small employers;

(B) Any adjustment, not to exceed fifteen percent (15%) annually and adjusted pro rata for rating periods

of less than one (1) year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business; and

(C) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the small employer carrier's rate manual for the class of business.

(iv) Adjustments in rates for claims experience, health status and duration from issue shall not be charged to individual employees or dependents. Any such adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer;

(v) Any adjustment in rates charged by a small employer carrier caused by reinsurance is subject to the rating limitations set forth in this section;

(vi) Premium rates for health benefit plans shall comply with the requirements of this section notwithstanding any assessments paid or payable by small employer carriers under this act;

(vii) In any case where a small employer carrier utilizes industry as a case characteristic in establishing premium rates, the rate factor associated with any industry classification shall not vary from the arithmetic average of the rate factors associated with all industry classifications by greater than fifteen percent (15%) of such coverage;

(viii) In the case of health benefit plans issued prior to the effective date of this act, a premium rate for a rating period may exceed the ranges set forth in paragraphs (i) and (ii) of subsection (a) of this section for a period of three (3) years following the effective date of this act. In such case, the percentage increase in the premium rate charged to a small employer in such a class of business for a new rating period may not exceed the sum of the following:

(A) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which a small employer carrier is no longer enrolling new small employers, the carrier shall use the percentage change in the base premium rate, provided that

the change does not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the carrier is actively enrolling new small employers; and

(B) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the carrier's rate manual for the class of business.

(ix) Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business;

(x) For the purposes of this subsection, a health benefit plan that utilizes a provider network shall not be considered similar coverage to a health benefit plan that does not utilize such a network, provided that utilization of the network results in substantial differences in claims costs;

(xi) The small employer carrier shall not use case characteristics, other than age, gender, industry, geographic area, family composition and group size without prior approval of the commissioner;

(xii) The commissioner shall adopt regulations to implement the provisions of this section and to assure that rating practices used by small employer carriers are consistent with the purposes of this act, including regulations that:

(A) Assure that differences in rates charged for health benefit plans by small employer carriers are reasonable and reflect objective differences in plan design;

(B) Prescribe the manner in which case characteristics may be used by small employer carriers.

(b) A small employer carrier shall not transfer a small employer involuntarily into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless the offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration of coverage since issue.

(c) The commissioner may suspend for a specified period the application of paragraph (a)(i) of this section as to the

premium rates applicable to one (1) or more small employers included within a class of business of a small employer carrier for one (1) or more rating periods upon a filing by the small employer carrier and a finding by the commissioner either that the suspension is reasonable in light of financial condition of the small employer carrier or that the suspension would enhance the efficiency and fairness of the marketplace for small employer health insurance.

(d) In connection with the offering for sale of any health benefit plan to a small employer, the small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of the following:

(i) The extent to which premium rates for a specified small employer are established or adjusted in part based upon the actual or expected variation in claims costs or actual or expected variation in health condition of the employees and dependents of the small employer;

(ii) The provisions concerning the small employer carrier's right to change premium rates and the factors other than claim experience which affect changes in premium rates;

(iii) The provisions relating to renewability of policies and contracts; and

(iv) The provisions relating to any preexisting condition provision.

(e) Each small employer carrier shall:

(i) Maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles;

(ii) File with the commissioner annually on or before March 15 an actuarial certification certifying that the carrier is in compliance with this act and that the rating methods of the small employer carrier are actuarially sound. A copy of the certification shall be retained by the small employer carrier at its principal place of business;

(iii) Make the information and documentation described in paragraph (i) of this subsection available to the commissioner upon request. Except in cases of violations of this act, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the commissioner to persons outside of the department except as agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

26-19-305. Renewability of coverage.

(a) A health benefit plan subject to this act shall be renewable with respect to all eligible employees or dependents at the option of the employer except in the following cases:

(i) Nonpayment of the required premiums;

(ii) Fraud or misrepresentation of the employer or, with respect to coverage of individual insureds, the insureds or their representatives;

(iii) Noncompliance with the carrier's minimum participation requirements;

(iv) Noncompliance with the carrier's employer contribution requirements;

(v) Repeated misuse of a provider network provision;

(vi) The carrier elects not to renew all of its health benefit plans issued to small employers in this state. In such a case, the carrier shall:

(A) Provide advanced notice of its decision under this paragraph to the commissioner in each state in which it is licensed; and

(B) Provide notice of the decision not to renew coverage to all affected health benefit plans and to the commissioner in each state in which an affected insured individual is known to reside at least one hundred eighty (180) days prior to the nonrenewal of any health benefit plans by the carrier. Notice to the commissioner under this subparagraph shall be provided at least three (3) working days prior to the notice to the affected health plans.

(vii) The commissioner finds that the continuation of the coverage would:

(A) Not be in the best interests of the policyholders or certificate holders; or

(B) Impair the carrier's ability to meet its contractual obligations.

(b) If the commissioner finds that the carrier may elect not to renew coverage under paragraph (vii) of subsection (a) of this section he shall assist affected small employers in finding replacement coverage.

(c) A carrier that elects not to renew a health benefit plan under paragraph (vi) of subsection (a) of this section shall be prohibited from writing new business in the small employer market for a period of five (5) years from the date of notice to the commissioner.

(d) In the case of a health maintenance organization doing business in the small employer market in one (1) established geographic service area of the state, the provisions set forth in this section shall apply to the health maintenance organization's operations in that service area.

26-19-306. Availability of coverage.

(a) Within one hundred eighty (180) days after the commissioner's approval of the basic health benefit plan and the standard health benefit plan developed pursuant to W.S. 26-19-308, but in no case prior to March 31, 1993, every small employer carrier shall, as a condition of transacting business in this state with small employers, actively offer to small employers all health benefit plans which it actively markets to small employers in this state, including at least two (2) health benefit plans. One (1) plan to be offered by each small employer carrier shall be a basic health benefit plan and one (1) plan shall be a standard health benefit plan. Except as provided in this section, all small employer carriers shall issue any health benefit plan to any eligible small employer that applies for the plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the plan. Carriers or multiple employer welfare associations whose bylaws or charters do not permit them to issue coverage on a marketwide basis shall only be required to guarantee issue to those small employers which meet the requirements of the bylaws

or charters. Charter or bylaw provisions which prohibit issuance to specific populations based on health status or health risk shall not be considered as exceptions to the requirements of this subsection.

(b) A small employer carrier shall file with the commissioner, in a format and manner prescribed by the commissioner, the basic health benefit plan and the standard health benefit plan to be used by the carrier. A plan filed pursuant to this section may be used by a small employer carrier beginning forty-five (45) days after it is filed unless the commissioner disapproves its use. The commissioner at any time may, after providing notice and an opportunity for a hearing to the small employer carrier, disapprove the continued use by a small employer carrier of a basic or standard health benefit plan on the grounds that the plan does not meet the requirements of this section.

(c) All health benefit plans covering small employers shall comply with the following provisions:

(i) Preexisting condition provisions shall not exclude coverage for a period beyond twelve (12) months following the individual's effective date of coverage and shall only relate to conditions for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage. Pregnancy shall not be treated as a preexisting condition. Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of a condition related to such information;

(ii) In determining whether a preexisting condition provision applies to an eligible employee or dependent, all health benefit plans shall credit the time the person was previously covered by public or private health insurance or other health benefit arrangement if the previous coverage was continuous to a date not more than ninety (90) days prior to the effective date of the new coverage, exclusive of any applicable waiting period under such plan;

(iii) Late enrollees may be excluded from coverage for the greater of eighteen (18) months or an eighteen (18) month preexisting condition exclusion, provided that if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period shall not exceed eighteen (18) months;

(iv) Any requirement used by a small employer carrier in determining whether to provide coverage to a small employer group, including requirements for minimum participation of eligible employees and minimum employer contributions, shall be applied uniformly among all small employer groups with the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier. A small employer carrier may vary application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group;

(v) In applying minimum participation requirements with respect to a small employer, a small employer carrier shall not consider employees or dependents who are otherwise covered by a public or an employment based health benefit plan in determining whether the applicable percentage of participation is met;

(vi) If a small employer carrier offers coverage to a small employer, it shall offer coverage to all of the small employer's eligible employees and may offer coverage to their dependents. A small employer carrier shall not offer coverage to only certain persons in a group or to only part of a group, except in the case of late enrollees as provided in paragraph (iii) of this subsection. Except as permitted under paragraphs (i) and (iii) of this subsection, a small employer carrier shall not modify a health benefit plan with respect to a small employer or any eligible employee or dependent, through riders, endorsements or otherwise, to restrict or exclude coverage or benefits for specified diseases, medical conditions or services otherwise covered by the plan;

(vii) In the case of a group health plan that offers medical care through health insurance coverage offered by a health maintenance organization, the plan may provide for an affiliation period with respect to coverage through the health maintenance organization only if:

(A) No preexisting condition exclusion is imposed with respect to such coverage;

(B) The affiliation period is applied uniformly without regard to any health status related factors; and

(C) The affiliation period does not exceed two (2) months, or three (3) months in the case of a late enrollee.

(d) No small employer carrier shall be required to offer coverage or accept applications pursuant to subsection (a) of this section in the case of the following:

(i) To a small employer, where the small employer is not physically located in the small employer carrier's established geographic service area;

(ii) To an employer whose employees do not work or reside within the small employer carrier's established geographic service area; or

(iii) Within an area where the small employer carrier reasonably anticipates, and demonstrates to the satisfaction of the commissioner, that it will not have the capacity within its established geographic service area to deliver service adequately to the members of such groups because of its obligations to existing group contract holders and enrollees.

(e) A small employer carrier that cannot offer coverage pursuant to paragraph (d)(iii) of this section shall not offer coverage in the applicable area to new cases of employer groups with more than fifty (50) eligible employees or small employer groups until the later of one hundred eighty (180) days following each such refusal or the date on which the carrier notifies the commissioner that it has regained capacity to deliver services to small employer groups.

(f) If any carrier has insured a disproportionate number of small employer groups with employees requiring reinsurance, the carrier may petition the commissioner to temporarily suspend the requirement to accept every small employer applying for coverage. The suspension may be granted only if the commissioner finds:

(i) The carrier is reasonably reinsuring lives at a rate of at least one hundred thirty percent (130%) of the statewide average for reinsurance; and

(ii) The rate of reinsurance is having a significant disproportional adverse effect on the carrier that is impairing its ability to offer policies at competitive rates in the small group market.

(g) A small employer carrier shall not be required to offer coverage or accept applications pursuant to subsection (a)

of this section for so long as the commissioner finds that the acceptance of an application or applications would place the small employer carrier in a financially impaired condition.

(h) The requirements of subsections (a) and (b) of this section shall not apply to any carrier which maintains existing health benefit plans covering eligible employees of one (1) or more small employers but is no longer enrolling new small employers.

(j) In addition to the prohibition on the use of genetic testing information provided in paragraph (c)(i) of this section, all health benefit plans covering small employers shall not, based on the genetic testing information of an individual or a family member of an individual:

(i) Establish rules of eligibility to enroll in the plan;

(ii) Deny eligibility;

(iii) Adjust premium rates;

(iv) Adjust contribution rates;

(v) Request or require predictive genetic testing information concerning an individual or a family member of the individual, except the health benefit plan may only request, but not require, predictive genetic testing information if needed for diagnosis, treatment or payment. As part of a request under this paragraph, the plan or issuer shall provide a description of the procedures in place to safeguard confidentiality of the information.

26-19-307. Small employer carrier reinsurance program.

(a) There is hereby created a nonprofit entity to be known as the "Wyoming small employer health reinsurance program" or "WySEHRP."

(b) Within sixty (60) days of a written request by the commissioner, each small employer carrier shall make a filing with the commissioner containing the carrier's net health insurance premium derived from health benefit plans delivered to small employers in this state in the previous calendar year.

(c) Participating carriers shall nominate board members which shall be subject to approval by the commissioner. The board shall consist of at least three (3) and not more than seven (7) representatives who shall serve three (3) year staggered terms. To the extent possible, the board shall include representation from carriers whose principal health insurance business is in the small employer market, health maintenance organizations and nonprofit health, hospital or medical service corporations. Members of the board shall be reimbursed from the assets of the program for expenses incurred by them as members of the board but shall not otherwise be compensated by the program for their services. The commissioner or the commissioner's designee shall be an ex officio voting member of the board. In approving the selection of the board, the commissioner shall assure that all participating carriers are fairly represented.

(d) If at any time there is no board, the commissioner may appoint an initial board.

(e) Within one hundred eighty (180) days after the selection or appointment of an initial board pursuant to subsection (d) of this section, the board shall submit to the commissioner a plan of operation and thereafter any amendments necessary or suitable, to assure the fair, reasonable and equitable administration of the program. The plan of operation shall be effective upon approval in writing by the commissioner consistent with the date on which the coverage under this section is available. Any plan of operation or amendments thereto, submitted to the commissioner by the board pursuant to this subsection shall be deemed approved by the commissioner if not expressly disapproved in writing by the commissioner within ninety (90) days of its receipt by the commissioner.

(f) Repealed by Laws 2017, ch. 58, § 2.

(g) The plan of operation shall:

(i) Establish procedures for handling and accounting of program assets and monies and for an annual fiscal reporting to the commissioner;

(ii) Establish terms of office and procedures for filling vacancies on the board, subject to the approval of the commissioner;

(iii) Establish procedures for selecting an administering carrier and setting forth the powers and duties of the administering carrier;

(iv) Establish procedures for reinsuring risks in accordance with the provisions of this act;

(v) Establish procedures for collecting assessments from participating carriers to provide for claims reinsured by the program and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made;

(vi) Provide for any additional matters at the discretion of the board.

(h) The program shall have the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health benefit plans directly to either groups or individuals. The program shall also have the specific authority to:

(i) Enter into contracts necessary or proper to carry out the provisions and purposes of this act, including the authority, with the approval of the commissioner, to enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions;

(ii) Sue or be sued, including taking any legal actions necessary or proper for recovering any assessments and penalties for, on behalf of, or against the program or any participating carriers;

(iii) Take any legal action necessary to avoid the payment of improper claims against the program;

(iv) Define the array of health coverage products for which reinsurance will be provided, and to issue reinsurance policies, in accordance with the requirements of this act;

(v) Establish rules, conditions and procedures pertaining to the reinsurance of participating carrier's risks by the program;

(vi) Establish actuarial functions as appropriate for the operation of the program;

(vii) Assess participating carriers in accordance with the provisions of subsection (g) of this section, and to make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Any interim assessments shall be credited as offsets against any regular assessments due following the close of the fiscal year;

(viii) Appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the program, policy and other contract design, and any other function within the authority of the program;

(ix) Borrow money to effect the purposes of the program. Any notes or other indebtedness of the program not in default shall be legal investments for carriers and may be carried as admitted assets;

(x) Adjust the five thousand dollar ($5,000.00) deductible reinsurance requirement contained in paragraph (j)(v) of this section to reflect the effects of inflation. The board annually shall adjust the deductible reinsurance requirement to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment shall not be less than the annual change in the medical component of the "Consumer Price Index for all Urban Consumers" of the department of labor, bureau of labor statistics, unless the board proposes and the commissioner approves a lower adjustment factor. Also, with the approval of the commissioner the board may increase or decrease the amount set forth in paragraph (j)(v) of this section and paragraphs (k)(i) and (ii) of this section if it is necessary to effectuate the purposes of this act and does not require participating carriers to retain an unreasonable level of risk.

(j) A participating carrier may reinsure with the program as provided for in this subsection:

(i) With respect to a basic health benefit plan or a standard health benefit plan, the program shall reinsure the level of coverage provided and, with respect to other plans, the program shall reinsure up to the level of coverage provided in a basic or standard health benefit plan;

(ii) Except in the case of a late enrollee, a participating carrier may reinsure an eligible employee or dependent within sixty (60) days of the commencement of the coverage of the small employer. A newly eligible employee or dependent may be reinsured within sixty (60) days of the commencement of his coverage;

(iii) A participating carrier may reinsure an entire employer group within sixty (60) days of the commencement of the group's coverage under the plan. The carrier may choose to reinsure newly eligible employees and dependents of a reinsured group pursuant to paragraph (ii) of this subsection;

(iv) Any eligible small employer group business in force before a program's plan of operation becomes effective shall be reinsured by the program only if the board determines that sufficient funding sources are available. The board shall adopt rules and regulations providing conditions under which reinsurance will be issued on employers, employees, or dependents who were subject to riders, endorsements or other contract provisions which restricted or excluded coverage or benefits for specified diseases, medical conditions or services otherwise covered by the plans if the provisions were in force prior to the effective date of the program's plan of operation. The reinsurance may be limited to coverage for the specified diseases, medical conditions or services that had previously been restricted or excluded by the riders, endorsements or other provisions;

(v) The program shall not reimburse a participating carrier with respect to the claims of a reinsured employee or dependent until the carrier has paid a deductible of five thousand dollars ($5,000.00) in a calendar year for benefits covered by the program. A participating carrier's liability under this paragraph shall not exceed a maximum limit of five thousand dollars ($5,000.00), in any one (1) calendar year with respect to any one (1) person reinsured. The amounts stated in this paragraph shall be increased in accordance with inflation adjustments made by the board under paragraph (h)(x) of this section;

(vi) A participating carrier may terminate reinsurance for all of the reinsured employees or dependents of a small employer on any plan anniversary;

(vii) Premium rates charged for reinsurance by the program to a health maintenance organization which is federally

qualified under 42 U.S.C. § 300 e(c)(2)(A) or a similar section subsequently enacted, and as such is subject to requirements that limit the amount of risk that may be ceded to the program that is more restrictive than paragraph (v) of this subsection, shall be reduced to reflect that portion of the risk above the amount set forth in paragraph (v) of this subsection that shall not be ceded to the program, if any;

(viii) The board may consider adjustments to the premium rates charged for reinsurance by the program for carriers using effective cost containment, including high-cost case management, as defined by the board;

(ix) A participating carrier shall apply its case management and claims handling techniques, including but not limited to utilization review, individual case management, preferred provider provisions, other managed care provisions or methods of operation, consistently with both reinsured and nonreinsured business.

(k) The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology shall include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology shall provide for the development of base reinsurance premium rates, which shall be multiplied by the factors set forth in paragraphs (i) and (ii) of this subsection to determine the premium rates for the program. The base reinsurance premium rates and number and type of insured groupings shall be established by the board, subject to the approval of the commissioner, and shall be set at levels which reasonably approximate gross premiums charged to small employers by small employer carriers. The board periodically shall review the methodology established under this subsection, including the system of classification and any rating factors, to assure that it reasonably reflects the claims experience of the program. The board may propose changes to the methodology which shall be subject to the approval of the commissioner. The board shall take steps to expand the usage of the reinsurance program and to reduce the impacts of high risk individuals on any particular group. Premiums for the program shall be as follows:

(i) An entire small employer group may be reinsured for a rate that is between one and one-tenth (1.1) and one and

one-half (1.5) times the base reinsurance premium rate for the group established pursuant to this subsection;

(ii) An eligible employee or dependent may be reinsured for a rate that is between one and one-half (1.5) and five (5) times the base reinsurance premium rate for the individual established pursuant to this subsection;

(iii) The premiums shall be kept as close as practical to the lower limits provided by this subsection except to the extent needed to keep the assessments needed within the forty percent (40%) of premium tax limit pursuant to W.S. 26-19-312(b).

(m) In any case where a health benefit plan for a small employer is entirely or partially reinsured with the program, the premium charged to the small employer for any rating period for the coverage issued shall be consistent with the requirements relating to premium rates set forth in W.S. 26-19-304(a).

(n) Assessments and other fees required by the program shall be made in accordance with this subsection:

(i) Repealed By Laws 2006, Chapter 120, § 3.

(ii) Repealed By Laws 2006, Chapter 120, § 3.

(iii) Repealed By Laws 2006, Chapter 120, § 3.

(iv) Repealed By Laws 2006, Chapter 120, § 3.

(v) Provisions shall be made in the plan of operation for the imposition of an interest penalty for late payment of assessments;

(vi) A participating carrier may seek from the commissioner a deferment in whole or in part, from any assessment issued by the board. The commissioner may defer, in whole or in part, the assessment of a participating carrier if, in the opinion of the commissioner, the payment of the assessment would place the participating carrier in a financially impaired condition. In the event an assessment against a participating carrier is deferred in whole or in part, the amount by which the assessment is deferred may be assessed against the other participating carriers in a manner consistent with the basis for the assessment set forth in this section.

The participating carrier receiving a deferment shall remain liable to the program for the amount deferred.

(o) Neither the participation in the program, the establishment of procedures, nor any other joint or collective action required by this act shall be the basis of any legal action, criminal or civil liability, or penalty against the program or any participating carriers either jointly or separately.

(p) The program shall be exempt from any and all taxes.

26-19-308. Health benefit plan committee.

(a) The commissioner shall appoint a health benefit plan committee. The committee shall be composed of seven (7) members, which shall include:

(i) The commissioner;

(ii) Three (3) representatives of participating carriers; and

(iii) One (1) representative each of a small employer, an employee of a small employer and a health care provider.

(b) The committee shall recommend the form and level of coverages to be made available by small employer carriers pursuant to W.S. 26-19-306.

(c) The committee shall recommend benefit levels, cost sharing factors, exclusions and limitations for the basic health benefit plan and the standard health benefit plan. One (1) basic health benefit plan and one (1) standard health care plan shall contain benefit and cost sharing levels that are consistent with the basic method of operation and the benefit plans of health maintenance organizations, including any restrictions imposed by federal law:

(i) The plans recommended by the committee may include cost containment features such as, but not limited to:

(A) Utilization review of health care services, including review of medical necessity of hospital and physician services;

(B) Case management benefit alternatives;

(C) Reasonable benefit differentials applicable to participating and nonparticipating providers; and

(D) Other managed care provisions.

(ii) The committee shall submit the plans to the commissioner for approval within one hundred eighty (180) days after the appointment of the committee pursuant to this section. If the commissioner disapproves of the plans in whole or in part he shall submit alternative interim plans to the committee for its approval.

(d) Members of the committee shall be reimbursed from the assets of the program for expenses incurred by them as members of the committee but shall not otherwise be compensated by the program for their services.

26-19-309. Periodic market evaluation.

The board shall study and report at least every three (3) years to the commissioner on the effectiveness of this act. The report shall analyze the effectiveness of this act in promoting rate stability, product availability and affordability of coverage and may contain recommendations for actions to improve the overall effectiveness, efficiency and fairness of the small group health insurance marketplace. The report also shall address whether carriers and producers are fairly and actively marketing or issuing health benefit plans to small employers in fulfillment of the purposes of this act and may contain recommendations for market conduct or other regulatory standards or action.

26-19-310. Administrative procedures.

The commissioner may issue regulations in accordance with W.S. 26-2-110 for the implementation and administration of the Small Employer Health Insurance Availability Act.

26-19-311. Small employer carrier reinsurance account created.

There is created an account in which all money received or collected to support the small employer carrier reinsurance program created pursuant to this act shall be credited and continuously appropriated for the purposes of this act. All

claims, insurer reimbursements, cost of administration and other necessary expenses incurred pursuant to this act shall be paid from the account. All money in the account not immediately necessary for the purposes of this act, which amount is certified by the board to the state treasurer, shall be invested and any interest earned shall be credited to the account.

26-19-312. Small employer carrier reinsurance program assessments; premium tax credit.

(a) After each calendar year, the board shall determine the amount of assessment needed to support the small carrier reinsurance program considering all payments made, costs incurred, premiums received and other income received.

(b) All authorized insurers liable for premium tax shall be assessed as necessary to meet the requirements determined under subsection (a) of this section. The assessment shall be in proportion to the gross premium tax owed and shall be expressed as a percentage of the gross premium tax owed. The gross premium tax is the premium tax owed before any deduction for any assessments. The assessment pursuant to this subsection for any individual insurer shall not exceed forty percent (40%) of the gross premium tax owed.

(c) On or before June 1 of each year, the board shall determine each insurer's assessment for the calendar year. Any deficit incurred by the program shall be recouped by assessment apportioned as provided by this section. Notification of assessments shall be mailed by the board not later than June 1 of each year.

(d) The total amount of assessment paid by any insurer pursuant to this section plus an amount equal to five percent (5%) of that total assessment shall be allowed as a credit against any premium or retaliatory tax owed by the member under this code for the year for which the assessment is payable. If assessments including the additional credit authorized exceed the premium or retaliatory tax owed considering all assessments pursuant to this act and other acts, the credits may be carried forward to other tax years until used.

(e) If assessments exceed actual losses and administrative expenses of the program, the excess shall be paid to the state treasurer, credited to the account created by W.S. 26-19-311 and used by the administrator to offset future losses or to reduce

program premiums. As used in this subsection, "future losses" includes reserves for incurred but unreported claims.

(f) The board may require initial calendar year 2006 and interim assessments as reasonably necessary for the organizational, administrative and interim operating expenses of the program and to pay claims in excess of premiums collected. Any initial or interim assessments shall be credited as offsets against any regular assessment due following the close of the calendar year.

(g) Assessments collected pursuant to the small employer carrier reinsurance program shall be paid to the state treasurer and credited to the account created by W.S. 26-19-311.

CHAPTER 20 - MANDATED COVERAGE

ARTICLE 1 - NEWBORN AND ADOPTED CHILDREN COVERAGE

26-20-101. Newly born and adopted child coverage required.

(a) All individual and group health insurance policies providing coverage on an expense incurred basis, and individual and group service or indemnity type contracts issued by any insurer including any nonprofit corporation which provide coverage for a family member of the insured or subscriber, shall also provide, as to the family members' coverage, that the health insurance benefits applicable for children are automatically payable with respect to:

(i) A newly born child of the insured or subscriber from the moment of birth; and

(ii) An adopted child from the earlier of the date the petition for adoption is filed or entry of the child in the adoptive home, except that when the child is in the custody of the state, coverage shall begin at the date of entry of a final decree of adoption. Coverage for an adopted child shall continue unless the petition is denied.

26-20-102. Specific coverage.

The coverage for newly born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. The coverage for adopted children shall consist of coverage of injury or sickness including the necessary care

and treatment of medical conditions existing prior to the date of placement.

26-20-103. Premiums.

If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a child or the placement for adoption of a child and payment of the required premium or fees shall be furnished to the insurer or nonprofit service or indemnity corporation within thirty-one (31) days after the date of birth or after the date coverage of a child placed for adoption begins in order to have the coverage continue beyond the thirty-one (31) day period.

26-20-104. Applicability of article.

The requirements of this article regarding newly born children apply to all insurance policies and subscriber contracts delivered or issued for delivery in this state more than one hundred twenty (120) days after May 30, 1975. The requirements of this article regarding adopted children apply to all insurance policies and subscriber contracts delivered or issued for delivery in this state after June 8, 1989.

ARTICLE 2 - DIABETES COVERAGE

26-20-201. Diabetes coverage required.

(a) All individual and group health insurance policies providing coverage on an expense incurred basis, individual and group service or indemnity type contracts issued by any insurer including any nonprofit corporation and individual and group service contracts issued by a health maintenance organization, which provide coverage shall also provide coverage for the equipment, supplies and outpatient self-management training and education, including medical nutrition therapy for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law. Covered diabetes outpatient self-management training and education shall be provided by a certified, registered or licensed health care professional with expertise in diabetes. For purposes of this section, required covered outpatient self-management training and education shall be limited to:

(i) A one-time evaluation and training program when medically necessary, within one (1) year of diagnosis;

(ii) Additional medically necessary self-management training shall be provided upon a significant change in symptoms, condition or treatment. This additional training shall be limited to three (3) hours per year.

(b) The benefits provided under this section shall be subject to the same annual deductibles or coinsurance established for all other covered benefits within a given policy. Private third-party payors may not reduce or eliminate coverage due to the requirements of this section. Enforcement of this section shall be performed by the commissioner or his designee.

(c) This section shall apply to a private health benefit plan as defined under W.S. 26-1-102(a)(xxxiii) delivered or issued on or after July 1, 2001.

ARTICLE 3 - CLINICAL TRIALS COVERAGE

26-20-301. Clinical trials and studies coverage required.

(a) All individual and group health insurance policies providing coverage on an expense incurred basis, individual and group service or indemnity type contracts issued by any insurer including any nonprofit corporation and individual and group service contracts or certificates issued by a health maintenance organization which provide coverage for treatment of cancer shall also provide coverage for routine patient care costs which a policyholder or certificate holder, or his covered dependent, receives as part of a clinical trial or study if:

(i) The medical treatment is provided in a phase II, phase III or phase IV study or clinical trial for the treatment of cancer;

(ii) The clinical trial or study is approved by:

(A) An agency of the national institutes of health as set forth in 42 U.S.C. 281(b) or a research entity that meets the NIH granting criteria;

(B) The United States food and drug administration as an application for a new investigational drug;

(C) The United States department of veterans affairs; or

(D) The United States department of defense.

(iii) The medical treatment is provided by a licensed health care provider practicing within the scope of the provider's license and the facility and personnel providing the treatment have the experience and training to provide the treatment in a competent manner; and

(iv) The participant in the clinical trial or study, before commencing participation, has signed a statement of consent indicating that the participant has been informed of:

(A) The procedure to be undertaken;

(B) Alternative methods of treatment; and

(C) The general nature and extent of risks associated with participation in the clinical trial or study.

(b) Coverage for medical treatment required by this section shall be limited to routine patient care costs.

(c) The coverage required by this section does not include:

(i) Any portion of the clinical trial or study that is customarily paid for by a government or a biotechnical, pharmaceutical or medical industry;

(ii) Coverage for any drug or device that is paid for by the manufacturer, distributor or provider of the drug or device;

(iii) Health care services that are customarily provided by the sponsors of the clinical trial or study free of charge to the participants in the trial or study;

(iv) Extraneous expenses related to participation in the clinical trial or study including, without limitation, travel, housing and other expenses that a participant or person accompanying a participant may incur;

(v) Any item or service that is provided solely to satisfy a need or desire for data collection or analysis that is not directly related to the clinical management of the patient;

(vi) Any costs for the management of research relating to the clinical trial or study.

(d) Nothing in this section shall:

(i) Preclude an insurer from excluding coverage for any claim arising from the practice of medicine or other health care by a person without an applicable physician or health care provider license;

(ii) Preclude an insurer from asserting the right to subrogate for expenses arising from complications caused by a drug or device that is subsequently approved for usage upon completion of the clinical trial;

(iii) Provide a private cause of action against any health insurer described in subsection (a) of this section for damages arising as a result of compliance with this section.

(e) For purposes of this section:

(i) "Clinical trial" means any experiment in which a drug is administered to, dispensed to or used by one (1) or more human subjects. For purposes of this paragraph, an experiment is any use of a drug except for the use of a marketed drug in the course of medical practice;

(ii) "Routine patient care cost" means:

(A) A medical service or treatment that is a benefit under a health plan that would be covered if the patient were receiving standard cancer treatment; or

(B) A drug provided to a patient during a cancer clinical trial, other than the drug that is the subject of the clinical trial, if the drug has been approved by the federal food and drug administration for use in treating the patient's particular condition.

ARTICLE 4 - INHERITED ENZYMATIC DISORDER COVERAGE

26-20-401. Inherited enzymatic disorder coverage required.

(a) All individual and group health insurance policies providing coverage on an expense incurred basis, individual and group service or indemnity type contracts issued by any insurer including any nonprofit corporation and individual and group service contracts issued by a health maintenance organization or delivered on or after July 1, 2013, shall provide coverage for the equipment, supplies and outpatient self-management training and education, including medical nutrition therapy for the treatment of inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic and fatty acids if prescribed by a health care professional legally authorized to prescribe such items under law. Covered inherited enzymatic disorder outpatient self-management training and education shall be provided by a certified, registered or licensed health care professional with expertise in inherited enzymatic disorders. For purposes of this section, required covered outpatient self-management training and education shall be limited to:

(i) A one (1) time evaluation and training program when medically necessary, within one (1) year of diagnosis;

(ii) Additional medically necessary self-management training shall be provided upon a significant change in symptoms, condition or treatment.

(b) For purposes of this section, "inherited enzymatic disorders" includes and is limited to phenylketonuria, maternal phenylketonuria, maple syrup urine disease, tyrosinemia, homocystinuria, histidinemia, urea cycle disorders, hyperlysinemia, glutaric acidemias, methylmalonic acidemia and propionic acidemia.

(c) The benefits provided under this section shall be subject to the same annual deductibles or coinsurance established for all other covered benefits within a given policy. Private third party payors may not refuse, reduce or eliminate coverage due to the requirements of this section. Enforcement of this section shall be performed by the commissioner or his designee.

(d) This section shall apply to both public and private health benefit plans, as defined in W.S. 26-1-102(a)(xxxiii) and (xxxiv), delivered or issued on or after July 1, 2013.

(e) Repealed by Laws 2020, ch. 87, § 3.

ARTICLE 5 - PRESCRIPTION EYE DROP REFILL COVERAGE

26-20-501. Prescription eye drop refill coverage required.

(a) All individual and group health insurance policies providing coverage on an expense incurred basis, individual and group service or indemnity type contracts issued by any insurer including any nonprofit corporation and individual and group service contracts or certificates issued by a health maintenance organization which provide coverage for prescription eye drops shall provide coverage for the following:

(i) A renewal of prescription eye drops if:

(A) The renewal is requested by the insured at least twenty-three (23) days for a thirty (30) day supply of eye drops, forty-five (45) days for a sixty (60) day supply of eye drops or sixty-eight (68) days for a ninety (90) day supply of eye drops from the later of the date that the original prescription was distributed to the insured or the date that the last renewal of the prescription was distributed to the insured; and

(B) The original prescription states that additional quantities are needed and that the renewal requested by the insured does not exceed the number of additional quantities needed.

(ii) One (1) additional bottle of prescription eye drops if:

(A) A bottle is requested by the insured or the practitioner at the time the original prescription is filled; and

(B) The original prescription states that one (1) additional bottle is needed by the insured for use in a day care center or school. The additional bottle shall be limited to one (1) every three (3) months.

(b) The benefits provided under this section shall be subject to the same annual deductibles, copayments or coinsurance established for all other covered benefits within a given policy. Private third party payors may not reduce or eliminate coverage due to the requirements of this section.

(c) This section shall apply to both private and public health benefit plans, as defined in W.S. 26-1-102(a)(xxxiii) and (xxxiv), delivered or issued on or after July 1, 2015.

ARTICLE 6 - ORAL CHEMOTHERAPY PARITY

26-20-601. Oral chemotherapy parity with injectable and intravenous.

(a) No individual or group health insurance policy providing coverage on an expense incurred basis, individual and group service or indemnity type contract issued by any insurer including any nonprofit corporation and individual and no group service contract issued by a health maintenance organization, shall require a higher copayment, deductible or coinsurance amount for oral chemotherapy than required for injected or intravenous chemotherapy, regardless of the formulation or benefit category determination by the policy or contract issuer.

(b) No issuer of a health insurance policy or contract shall comply with subsection (a) of this section by increasing the copayment, deductible or coinsurance amount required for covered injected or intravenous chemotherapy or by reclassifying benefits with respect to cancer treatment medications.

(c) This section shall apply to all policies and contracts, as described in subsection (a) of this section, issued or renewed after July 1, 2015.

(d) For purposes of this section, "chemotherapy" means administration of drugs and biologics to kill, slow or prevent the growth of cancerous cells.

ARTICLE 7 - MENTAL HEALTH AND SUBSTANCE USE DISORDER INSURANCE PARITY

26-20-701. Required parity for mental health and substance use disorder insurance.

(a) All individual or group health insurance policies providing coverage on an expense incurred basis, individual and group service or indemnity type health insurance contracts issued by any insurer, including any nonprofit corporation and individual and group service contracts issued by a health maintenance organization, shall meet the requirements of, and the commissioner may enforce subject to the provisions of this section, the Mental Health Parity and Addiction Equity Act of

2008, 42 U.S.C. § 300gg-26, as amended, and the regulations promulgated pursuant thereto as of January 1, 2018. Persons exempt from complying with the Mental Health Parity and Addiction Equity Act shall not be exempted from complying with the requirements of this section if this section otherwise applies to the person. The commissioner may promulgate reasonable rules which establish exemptions from the application of this section.

(b) No policy or contract providing mental health or substance use coverage to which subsection (a) of this section applies shall:

(i) Deny coverage for mental health or substance use services delivered using remote audio or audio-visual delivery systems to a person not physically present with the delivering health care provider if coverage would be provided for the same services when delivered in person;

(ii) Charge a copayment, deductible or coinsurance amount to a person receiving mental health or substance use services through remote audio or audio-visual delivery systems that is higher than the copayment, deductible or coinsurance amount charged for the same services when delivered in person;

(iii) Reduce any payment or reimbursement provided to a health care provider using remote audio or audio-visual delivery systems for the provision of mental health or substance use services to an amount that is less than the payment or reimbursement that would be made to a health care provider rendering those services in person.

26-20-702. Reimbursement for mental health and substance use disorder benefits.

(a) As used in this section "mental health and substance use disorder benefits" means benefits for the treatment of any condition or disorder that involves a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental disorders section of the most recent edition of the International Classification of Disease or that is listed in the mental disorders section of the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

(b) All individual or group health insurance policies providing coverage on an expense incurred basis, individual and

group service or indemnity type health insurance contracts issued by any insurer, including any nonprofit corporation and individual and group service contracts issued by a health maintenance organization and individual and group service contracts that provide mental health and substance use disorder benefits shall provide reimbursement for benefits that are delivered through the psychiatric Collaborative Care Model as defined by the American Medical Association's most recent procedural terminology codes and where a licensed and credentialed primary care team consists of a primary care provider, a care manager and a psychiatric consultant.

(c) The benefit and reimbursement requirements of subsection (b) of this section shall not apply to any policy, contract or service that would require the state to defray the cost as specified in 42 U.S.C. 18031(d)(3)(B)(ii).

(d) Nothing in this section shall restrict the health insurer's ability to apply appropriate medical management for the services rendered.

ARTICLE 8 - ANATOMICAL GIFTS AND ORGAN TRANSPLANTATION

26-20-801. Definitions.

(a) As used in this article:

(i) "Covered person" means a policyholder, subscriber, enrollee, member or individual covered by any policy, contract or certificate listed in W.S. 26-20-802(a) or by any life insurance or long-term care insurance policy;

(ii) "Health insurance issuer" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including through a policy, contract or certificate listed in W.S. 26-20-802(a), and shall include a sickness and accident insurance company, a nonprofit corporation, a health maintenance organization, a preferred provider organization, or any similar entity, or any other entity providing a plan of health insurance or health benefits;

(iii) "Living organ donor" means a person who is not deceased and who has donated all or part of one (1) or more of

the person's own organs or tissues to another person for transplant;

(iv) "Organ transplant recipient" means a person who receives an organ transplant as defined by W.S. 35-5-301(a)(v).

(b) The definitions in W.S. 35-5-301 shall apply to this article.

26-20-802. Discrimination prohibited.

(a) No individual or group health insurance policy providing coverage on an expense incurred basis, individual or group service or indemnity type health insurance contract or certificate issued by any health insurance issuer that provides coverage for anatomical gifts, organ transplants or related treatment and services shall:

(i) Deny coverage of an anatomical gift, organ transplant or related treatment or service to a covered person solely on the basis of the person's disability;

(ii) Deny to a covered person eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the policy, contract or certificate, solely for the purpose of avoiding the requirements of this section or W.S. 35-5-301 through 35-5-303;

(iii) Penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide monetary or nonmonetary incentives to an attending provider, to induce the provider to provide care to a covered person in a manner inconsistent with this section or W.S. 35-5-301 through 35-5-303; or

(iv) Reduce or limit coverage benefits to a covered person for the medical services or other services related to organ transplantation performed pursuant to this section and W.S. 35-5-301 through 35-5-303 as determined in consultation with the attending physician and covered person.

(b) In the case of any policy, contract or certificate listed in subsection (a) of this section that is maintained pursuant to one (1) or more collective bargaining agreements between employee representatives and one (1) or more employers, any policy, contract or certificate amendment made pursuant to a collective bargaining agreement relating to the policy and made

solely to conform to any requirement under this section shall not be treated as a termination of the collective bargaining agreement.

(c) Nothing in this section shall require a health insurance issuer to provide coverage for a medically inappropriate organ transplant.

26-20-803. Living organ donor and organ transplant recipient coverage.

(a) No individual or group life insurance policy or long-term care insurance policy shall:

(i) Deny or cancel coverage to a covered person solely on the basis of the person's status as a living organ donor or as an organ transplant recipient without any unique and material actuarial risks in accordance with sound actuarial principles and without any actual and reasonably anticipated and expected experience of a person on the basis of their status as a living organ donor or as an organ transplant recipient;

(ii) Deny a covered person eligibility or continued eligibility to enroll or to renew coverage under the terms of a policy, contract or certificate, solely on the basis of the person's status as a living organ donor or as an organ transplant recipient without any unique and material actuarial risks in accordance with sound actuarial principles and without any actual and reasonably anticipated and expected experience of a person on the basis of their status as a living organ donor or as an organ transplant recipient;

(iii) Reduce or limit coverage or benefits, increase the premiums or otherwise adversely affect the coverage or cost for a covered person's policy, contract or certificate solely on the basis of the person's status as a living organ donor or as an organ transplant recipient without any additional separate actuarial risk involved;

(iv) Preclude a covered person from donating all or part of an organ or tissues as a condition of receiving or continuing to receive coverage under a policy, contract or certificate;

(v) Preclude a covered person from receiving all or part of an organ or tissue through transplantation or

transfusion as a condition of receiving or continuing to receive coverage under a policy, contract or certificate;

(vi) Preclude a covered person from receiving medical services or other services related to organ transplantation, including diagnostic services, evaluation, surgery, counseling or post-operative treatment or services.

CHAPTER 21 - CREDIT LIFE AND DISABILITY INSURANCE

26-21-101. Scope and applicability of chapter.

(a) All life insurance and all disability insurance in connection with loans or other credit transactions is subject to this chapter, except that insurance is not subject to this chapter if:

(i) It is in connection with a loan or other credit transaction of more than ten (10) years; or

(ii) The issuance of that insurance is an isolated transaction by the insurer not related to an agreement or a plan or regular course of conduct for insuring debtors of the creditor.

26-21-102. Definitions.

(a) For the purpose of this chapter:

(i) "Credit life insurance" means insurance on the life of a debtor pursuant to or in connection with a specific loan or other credit transaction;

(ii) "Credit disability insurance" means insurance on a debtor to provide indemnity for payments becoming due on a specific loan or other credit transaction while the debtor is disabled as defined in the policy;

(iii) "Creditor" means the lender of money or vendor of goods, services or property, including a lessor under a lease intended as a security, rights or privileges, for which payment is arranged through a credit transaction, or any successor to the right, title or interest of any such lender or vendor, and an affiliate, associate or subsidiary of any of them or any director, officer or employee of any of them or any other person in any way associated with any of them;

(iv) "Debtor" means a borrower of money or a purchaser or lessee of goods, services, property, rights or privileges for which payment is arranged through a credit transaction;

(v) "Indebtedness" means the total amount payable by a debtor to a creditor in connection with a loan or other credit transaction.

26-21-103. Forms of credit life and credit disability insurance.

(a) Credit life insurance and credit disability insurance shall be issued only in the following forms:

(i) Individual policies of life insurance issued to debtors on the term plan;

(ii) Individual policies of disability insurance issued to debtors on a term plan, or disability benefit provisions in individual policies of credit life insurance;

(iii) Group policies of life insurance issued to creditors providing insurance upon the lives of debtors on the term plan;

(iv) Group policies of disability insurance issued to creditors on a term plan insuring debtors, or disability benefit provisions in group credit life insurance policies to provide disability coverage.

26-21-104. Amount of credit life insurance.

(a) The initial amount of credit life insurance shall not exceed the total amount repayable under the contract of indebtedness.

(b) If an indebtedness is repayable in substantially equal installments, the amount of insurance shall not exceed the scheduled or actual amount of unpaid indebtedness, whichever is greater.

(c) Notwithstanding subsections (a) and (b) of this section, insurance on agricultural credit transactions not exceeding two (2) years in duration may be written up to the amount of the loan commitment on a nondecreasing or level term plan.

(d) Notwithstanding any other provision of law, insurance on educational credit transaction commitments may be written for the amount of the portion of that commitment that the creditor has not advanced.

26-21-105. Credit disability insurance.

The total amount of indemnity payable by credit disability insurance in case of disability, as defined in the policy, shall not exceed the aggregate of the periodic scheduled unpaid installments of the indebtedness, and the amount of each periodic indemnity payment shall not exceed the original indebtedness divided by the number of periodic installments.

26-21-106. Term of insurance.

(a) The term of any credit life insurance or credit disability insurance, subject to the insurer's acceptance, commences on the date when the debtor becomes obligated to the creditor, or the date when the debtor applies for the insurance, whichever is later, except that if a group policy provides coverage with respect to the existing obligations, the insurance on a debtor with respect to the indebtedness commences on the effective date of the policy.

(b) If evidence of insurability is required and that evidence is furnished more than thirty (30) days after the date when the debtor becomes obligated to the creditor, the term of the insurance may commence on the date on which the insurer determines the evidence to be satisfactory, and in that case there shall be an appropriate refund or adjustment of any charge to the debtor for insurance. The term of the insurance shall not extend more than fifteen (15) days beyond the scheduled maturity date of the indebtedness except when extended without additional cost to the debtor.

(c) If the indebtedness is discharged because of renewal or refinancing prior to the scheduled maturity date, the insurance in force shall be terminated before any new insurance may be issued in connection with the renewed or refinanced indebtedness.

(d) In all cases of termination prior to scheduled maturity, a refund shall be paid or credited as provided in W.S. 26-21-109.

26-21-107. Provisions of policies and certificates; disclosure to debtors.

(a) All credit life insurance and credit disability insurance shall be evidenced by an individual policy, or in the case of group insurance by a certificate of insurance, which individual policy or group certificate shall be delivered to the debtor.

(b) Each individual policy or group certificate of credit life insurance or credit disability insurance, or both, in addition to other requirements of law, shall:

(i) Set forth:

(A) The insurer's name and home office address;

(B) The identity by name or otherwise of the persons insured;

(C) The premium amount of payment, if any, by the debtor separately for credit life insurance and credit disability insurance;

(D) A description of the amount, term and coverage including any exceptions, limitations and restrictions; and

(ii) State that the benefits shall be paid to the creditor to reduce or extinguish the unpaid indebtedness and, if the amount of insurance exceeds the unpaid indebtedness, the excess is payable to a beneficiary, other than the creditor, named by the debtor or to his estate.

(c) Except as otherwise provided in this section, the individual policy or group certificate of insurance shall be delivered to the insured debtor at the time the indebtedness is incurred.

(d) If a debtor makes a separate payment for credit life or credit disability insurance and an individual policy or group certificate of insurance is not delivered to the debtor at the time the indebtedness is incurred, a copy of the application for the policy or a notice of proposed insurance shall be delivered at that time to the debtor. The copy of the application for, or notice of proposed insurance, shall:

(i) Be signed by the debtor and shall set forth:

(A) The identity by name or otherwise of the person or persons insured;

(B) The premium or amount of payment by the debtor, if any, separately for credit life insurance and credit disability insurance; and

(C) A statement that within thirty (30) days, if the insurer accepts the insurance, there shall be delivered to the debtor an individual policy or group certificate of insurance containing:

(I) The insurer's name and home office address;

(II) A description of the amount, term and coverage including any exceptions, limitations and restrictions.

(ii) Refer exclusively to insurance coverage and shall be separate from the loan, sale or other credit statement of account, instrument or agreement, unless the information required by this subsection is prominently set forth in the copy of the application or the notice of proposed insurance.

(e) Upon the insurer's acceptance of the insurance and within thirty (30) days from the date the indebtedness is incurred, the insurer shall cause the individual policy or group certificate of insurance to be delivered to the debtor. The application or notice of proposed insurance shall state that upon the insurer's acceptance, the insurance is effective as provided in W.S. 26-21-106.

(f) If the named insurer does not accept the risk, the debtor shall receive a policy or certificate of insurance setting forth the name and home office address of the substituted insurer and the amount of the premium to be charged. If the amount of premium is less than that set forth in the notice of proposed insurance, an appropriate refund shall be made.

26-21-108. Filing of policies with commissioner; approval or disapproval; withdrawal of approval.

(a) All policies, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements and

riders delivered or issued for delivery in this state and the schedule of premium rates pertaining thereto shall be filed with the commissioner.

(b) The commissioner, within thirty (30) days after the filing of any such policies, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements and riders, shall disapprove any such form if the premium rates charged or to be charged are excessive in relation to benefits, or if it contains provisions which are unjust, unfair, inequitable, misleading, deceptive or encourage misrepresentation of the coverage, or are contrary to any provision of this code or of any rule or regulation promulgated under this code. In determining whether to disapprove any form the commissioner shall consider past and prospective loss experience within and outside this state, underwriting practice and judgment to the extent appropriate and any other relevant factors within and outside this state.

(c) If the commissioner notifies the insurer that the form is disapproved, it is unlawful for the insurer to issue or use that form. The commissioner shall specify in the notice the reason for his disapproval and state that a hearing will be granted within twenty (20) days after request in writing by the insurer. No policy, certificate of insurance, notice of proposed insurance, application, endorsement or rider shall be issued or used until the expiration of thirty (30) days after it is filed, unless the commissioner gives his prior written approval thereto.

(d) The commissioner, at any time after a hearing held not less than twenty (20) days after written notice to the insurer, may withdraw his approval of any form on any ground set forth in subsection (b) of this section. The written notice of hearing shall state the reason for the proposed withdrawal.

(e) The insurer shall not issue or use any form after the effective date of withdrawal.

(f) If a group policy of credit life insurance or credit disability insurance is delivered in another state, the insurer shall file only the group certificate and notice of proposed insurance delivered or issued for delivery in this state as specified in W.S. 26-21-107(b) and (d). The commissioner shall approve the forms if they conform with the requirements specified in W.S. 26-21-107(b) and (d) and if the schedules of premium rates applicable to the insurance evidenced by the

certificate or notice are not in excess of the insurer's schedules of premium rates filed with the commissioner.

26-21-109. Schedules of premiums; refunds.

(a) Any insurer may revise its schedules of premium rates and shall file the revised schedules with the commissioner. No insurer shall issue any credit life insurance or credit disability insurance policy for which the premium rate exceeds that determined by the insurer's schedules then on file with the commissioner.

(b) Each individual policy or group certificate shall provide that if the insurance is terminated prior to the scheduled maturity date of the indebtedness, any refund of an amount paid by the debtor for insurance shall be paid or credited promptly to the person entitled thereto. The commissioner shall prescribe a minimum refund and no refund less than the minimum need be made. The formula to be used in computing the refund shall be filed with and approved by the commissioner.

(c) If a creditor requires a debtor to make any payment for credit life insurance or credit disability insurance and an individual policy or group certificate of insurance is not issued, the creditor shall immediately give written notice to the debtor and shall promptly make an appropriate credit to the account.

(d) The amount charged to a debtor for any credit life or credit disability insurance shall not exceed the premiums charged by the insurer, as computed at the time the charge to the debtor is determined.

26-21-110. Collection of premiums.

The insurance premium or other identifiable charge for credit life or credit disability insurance may be collected from the insured or included in the principal of any loan or other transaction at the time the transaction is completed. If included in the principal of the loan or other transaction, a statement that the premium is included in the principal and the amount of the premium shall be legible on the face of the policy or certificate in a size larger than the type used in the body of the policy or certificate.

26-21-111. Premium not deemed interest; gains to creditor not violation.

The premium or cost of credit life or credit disability insurance when issued through any creditor is not deemed interest or charges, or consideration or an amount in excess of permitted charges in connection with the loan or other credit transaction. Any gain or advantage to the creditor arising out of the premium or commission or dividend from the issuance of the insurance is not a violation of any other law of this state.

26-21-112. Issuance and delivery of policies.

All credit life insurance and credit disability insurance policies shall be delivered or issued for delivery in this state only by an insurer authorized to transact insurance in this state and shall be issued only through holders of licenses or authorizations issued by the commissioner.

26-21-113. Claims.

(a) All claims shall be:

(i) Promptly reported to the insurer or its designated claim representative, and the insurer shall maintain adequate claim files;

(ii) Settled as soon as possible and in accordance with the terms of the insurance contract;

(iii) Paid either by draft drawn upon the insurer or by check of the insurer to the order of the claimant to whom payment of the claim is due pursuant to the policy provisions, or upon direction of the claimant to one specified.

(b) No plan or arrangement shall be used whereby any person other than the insurer or its designated claim representative is authorized to settle or adjust claims. The creditor shall not be designated as claim representative for the insurer in adjusting claims, except that a group policyholder, by arrangement with the group insurer, may draw drafts or checks in payment of claims due to the group policyholder subject to the insurer's audit and review.

26-21-114. Choice of debtor to use existing insurance or new insurance for additional security.

If credit life insurance or credit disability insurance is required as additional security for any indebtedness, the debtor, upon request to the creditor, has the option of furnishing the required amount of insurance through existing insurance policies which he owns or controls or of procuring and furnishing the required coverage through any insurer authorized to transact insurance within this state.

CHAPTER 22 - HOSPITAL OR MEDICAL SERVICE INSURANCE AND PREPAID HEALTH SERVICE PLANS

ARTICLE 1 - REIMBURSEMENT UNDER MEDICAL SERVICE CONTRACT OR DISABILITY INSURANCE POLICY

26-22-101. Reimbursement for health services provided by licensed practitioner or registered dietitian not to be denied.

(a) Notwithstanding any provision of any medical service contract or policy of disability insurance or certificate to the contrary if a medical service contract or insurance policy or certificate provides for reimbursement to the insured or subscriber for health services, reimbursement in amounts provided under the contract or insurance policy shall not be denied if the services are rendered to the insured or subscriber by a person licensed under the laws of this state to treat the illness or disability or perform the health services covered by the contract or policy. Nothing in this section prevents the insured from contracting with the insurer for direct payment of policy proceeds to the provider of health services.

(b) For purposes of reimbursements provided by subsection (a) of this section for dietary services, a dietitian registered with the commission on dietetic registration of the American dietetic association shall be deemed a "person licensed" within the meaning of subsection (a) and benefits otherwise provided by the contract shall be provided. Nothing in this section shall require a disability insurer to pay for services provided by a dietitian or a registered dietitian unless otherwise provided as a benefit in the contract or policy.

26-22-102. Requirements of accident and sickness insurance to tax supported institutions.

(a) No individual or group policy of accident and sickness insurance delivered or issued for delivery to any person in this state which provides coverage for mental illness or intellectual disability or both shall exclude benefits for the care or

treatment of the mental illness or intellectual disability provided by a tax supported institution of the state, provided:

(i) The institution establishes and actively utilizes appropriate professional standard review organizations according to W.S. 35-17-101, or comparable peer review programs;

(ii) The operation of the institution is subject to review according to federal and state law; and

(iii) Charges are made for the services.

26-22-103. Applicability; compliance by use of endorsements or riders.

W.S. 26-22-102 and this section apply to all accident and sickness policies issued and delivered in the state or issued for delivery in the state after January 1, 1976, but do not apply to any policies issued and delivered in the state or issued for delivery in the state prior to that date. With respect to any policy forms approved by the insurance commission prior to January 1, 1976, an insurer is authorized to achieve compliance by the use of endorsements or riders if the endorsements or riders are approved by the insurance commission as being in compliance with W.S. 26-22-102.

26-22-104. Reimbursement for health care; includes health care by psychologists.

Notwithstanding any provisions in policies or contracts or certificates issued as evidence thereof which might be construed to the contrary, from and after July 1, 1985, all individual and group or blanket policies of accident and sickness insurance or individual or group service or indemnity contracts issued by a corporation including corporations which provide health care to its employees as a benefit of employment which are issued, delivered, issued for delivery, amended or renewed in this state or which cover any risk resident, located or to be performed in this state and which provide coverage for diagnostic and therapeutic services which are within the lawful scope of practice of a psychologist duly licensed to practice, shall be deemed to provide that any person covered under the policies or contracts is entitled to receive reimbursement for the services under the policies or contracts if they are rendered by a duly licensed doctor of medicine or a duly licensed psychologist.

ARTICLE 2 - GROUP HEALTH INSURANCE CONVERSION

26-22-201. Group health insurance conversion.

A group policy or certificate delivered or issued for delivery in this state which provides hospital, surgical or major medical expense insurance, or any combination 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 an employee or member whose insurance under the group policy has been terminated for any reason and who has been continuously insured under the group policy, and under any group policy providing similar benefits which it replaces, for at least three (3) months immediately prior to termination, is entitled to have the insurer issue to him a policy of health insurance, referred to in this article as the converted policy. An employee or member is not entitled to have a converted policy issued to him if termination of his insurance under the group policy occurred because he failed to pay any required contribution, or any discontinued group coverage was replaced by similar group coverage within thirty-one (31) days from the date of discontinuation.

26-22-202. Issuance of a converted policy; conditions.

(a) Issuance of a converted policy is subject to the following conditions:

(i) Written application for the converted policy shall be made and the first premium paid to the insurer not later than thirty-one (31) days after termination of the insured's coverage by the group policy and termination of the subsequent continuation rights offered by the group policy;

(ii) The effective date of the converted policy is the day following the termination of the insured's coverage under the group policy and termination of the subsequent continuation rights offered by the group policy;

(iii) The converted policy shall:

(A) Cover the employee or member and his dependents who were covered by the group policy on the date of termination of insurance, and at the insurer's option, a separate converted policy may be issued to cover any dependent;

(B) Be issued without evidence of insurability;

(C) Not exclude a preexisting condition not excluded by the group policy.

(iv) The insurer is not required to issue a converted policy:

(A) Covering any person if the person is or could be covered by Medicare (Title XVIII of the United States Social Security Act as added by the Social Security Amendments of 1965 or as later amended or superseded);

(B) Covering any person if:

(I) The person is covered for similar benefits by another hospital, surgical, medical or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program; or

(II) The person is eligible for similar benefits, whether or not covered therefor, under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or

(III) Similar benefits are provided for or available to the person, pursuant to or in accordance with the requirements of any state or federal law; and

(IV) The benefits provided under the sources referred to in subdivision (B)(I) of this paragraph for the person or benefits provided or available under the sources referred to in subdivisions (B)(II) and (III) of this paragraph for the person, together with the benefits provided by the converted policy, would result in overinsurance according to the insurer's standards. The insurer's standards must bear some reasonable relationship to actual health care costs in the area in which the insured lives at the time of conversion and must be filed with the commissioner prior to their use in denying coverage;

(V) Which provides benefits in excess of those provided under the group policy from which conversion is made.

(v) A converted policy may:

(A) Include a provision whereby the insurer may request information in advance of any premium due date of the policy of any person covered thereunder as to whether:

(I) He is covered for similar benefits by another hospital, surgical, medical or major medical expense insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan or by any other plan or program;

(II) He is covered for similar benefits under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or

(III) Similar benefits are provided for or available to the person, pursuant to or in accordance with the requirements of any state or federal law.

(B) Provide that the insurer may refuse to renew the policy or the coverage of any person insured thereunder for the following reasons only:

(I) Either the benefits provided under the sources referred to in subdivisions (A)(I) and (II) of this paragraph for the person or benefits provided or available under the sources referred to in subdivision (A)(III) of this paragraph for the person, together with the benefits provided by the converted policy, would result in overinsurance according to the insurer's standards on file with the commissioner, or the converted policyholder fails to provide the requested information;

(II) Fraud or material misrepresentation in applying for any benefits under the converted policy;

(III) Eligibility of the insured person for coverage under Medicare (Title XVIII of the United States Social Security Act as added by the Social Security Amendments of 1965 or as later amended or superseded) or under any other state or federal law providing for benefits similar to those provided by the converted policy;

(IV) Other reasons the commissioner approves.

(C) Provide that any hospital, surgical or medical benefits payable thereunder may be reduced by the amount

of any such benefits payable under the group policy after the termination of the individual's insurance under the group policy;

(D) Provide that during the first policy year the benefits payable under the converted policy, together with the benefits payable under the group policy, shall not exceed those that would have been payable had the individual's insurance under the group policy remained in force and effect;

(E) Provide for reduction of coverage on any person upon his eligibility for coverage under Medicare (Title XVIII of the United States Social Security Act as added by the Social Security Amendments of 1965 or as later amended or superseded) or under any other state or federal law providing for benefits similar to those provided by the converted policy.

(vi) Subject to the provisions and conditions of this section:

(A) If the group insurance policy from which conversion is made insures the employee or member for:

(I) Basic hospital or surgical expense insurance, the employee or member is entitled to obtain a converted policy providing, at his option, coverage on an expense incurred basis under any one (1) of the plans meeting the following requirements:

(1) Plan A:

a. Hospital room and board daily expense benefits in a maximum dollar amount approximating the average semiprivate rate charged in metropolitan areas of this state, for a maximum duration of seventy (70) days;

b. Miscellaneous hospital expense benefits of a maximum amount of ten (10) times the hospital room and board daily expense benefits; and

c. Surgical operation expense benefits according to a surgical schedule consistent with those customarily offered by the insurer under group or individual health insurance policies and providing a maximum benefit of eight hundred dollars ($800.00); or

(2) Plan B:

a. Hospital room and board daily expense benefits in a maximum dollar amount equal to seventy-five percent (75%) of the maximum dollar amount determined for Plan A, for a maximum duration of seventy (70) days;

b. Miscellaneous hospital expense benefits of a maximum amount of ten (10) times the hospital room and board daily expense benefits; and

c. Surgical operation expense benefits according to a surgical schedule consistent with those customarily offered by the insurer under group or individual health insurance policies and providing a maximum benefit of six hundred dollars ($600.00); or

(3) Plan C:

a. Hospital room and board daily expense benefits in a maximum dollar amount equal to fifty percent (50%) of the maximum dollar amount determined for Plan A, for a maximum duration of seventy (70) days;

b. Miscellaneous hospital benefits of a maximum amount of ten (10) times the hospital room and board daily expense benefits; and

c. Surgical operation expense benefits according to a surgical schedule consistent with those customarily offered by the insurer under group or individual health insurance policies and providing a maximum benefit of four hundred dollars ($400.00);

d. The maximum dollar amounts in Plan A shall be determined by the commissioner and may be redetermined by him from time to time as to converted policies issued subsequent to the redetermination, except that no redetermination shall be made more often than once in three (3) years and the maximum dollar amounts in Plans A, B and C shall be rounded to the nearest multiple of ten dollars ($10.00).

(II) Major medical expense insurance, the employee or member is entitled to obtain a converted policy providing catastrophic or major medical coverage under a plan meeting the following requirements:

(1) A maximum benefit at least equal to either, at the insurer's option, subdivisions (1) or (2) of this subdivision:

a. The smaller of the following amounts:

i. The maximum benefit provided under the group policy;

ii. A maximum payment of two hundred fifty thousand dollars ($250,000.00) per covered person for all covered medical expenses incurred during the covered person's lifetime.

b. The smaller of the following amounts:

(2) Payment of benefits at the rate of eighty percent (80%) of covered medical expenses which are in excess of the deductible, until twenty percent (20%) of those expenses in a benefit period reaches one thousand dollars ($1,000.00), after which benefits will be paid at the rate of one hundred percent (100%) during the remainder of the benefit period, except that payment of benefits for outpatient treatment of mental illness, if provided in the converted policy, may be at a lesser rate but not less than fifty percent (50%);

i. The maximum benefit provided under the group policy;

ii. A maximum payment of two hundred fifty thousand dollars ($250,000.00) for each unrelated injury or sickness.

(3) A deductible for each benefit period which, at the insurer's option, shall be either the sum of the benefits deductible and one hundred dollars ($100.00), or the corresponding deductible in the group policy.

(B) The conversion privilege shall also be available to:

(I) The surviving spouse, if any, at the death of the employee or member, with respect to the spouse and the children whose coverage under the group policy terminates by reason of the death, otherwise to each surviving child whose coverage under the group policy terminates by reason of the

death, or if the group policy provides for continuation of dependent's coverage following the employee's or member's death, at the end of the continuation;

(II) The spouse of the employee or member upon termination of coverage of the spouse, while the employee or member remains insured under the group policy, by reason of ceasing to be a qualified family member under the group policy, with respect to the spouse and the children whose coverage under the group policy terminates at the same time; or

(III) A child solely with respect to himself upon termination of his coverage by reason of ceasing to be a qualified member under the group policy, if a conversion privilege is not otherwise provided in this section with respect to the termination.

(vii) If the maximum benefit is determined by subdivision (A)(II)(1)b. of this paragraph, the insurer may require that the deductible be satisfied during a period of not less than three (3) months if the deductible is one hundred dollars ($100.00) or less, and not less than six (6) months if the deductible exceeds one hundred dollars ($100.00);

(viii) The benefit period shall be each calendar year when the maximum benefit is determined by subdivision (A)(II)(1) of this paragraph or twenty-four (24) months when the maximum benefit is determined by subdivision (A)(II)(1)b. of this paragraph;

(ix) Any surgical schedule shall be consistent with those customarily offered by the insurer under group or individual health insurance policies and shall provide at least a one thousand two hundred dollar ($1,200.00) maximum benefit;

(x) As used in paragraph (vi) of this subsection:

(A) "Benefits deductible" means the value of any benefits provided on an expense incurred basis which are provided with respect to covered medical expenses by any other hospital, surgical or medical insurance policy or hospital or medical service subscriber contract or medical practice or other prepayment plan, or any other plan or program whether on an insured or uninsured basis, or in accordance with the requirements of any state or federal law and, if pursuant to paragraph (viii) of this subsection, the converted policy

provides both basic hospital or surgical coverage and major medical coverage, the value of the basic benefits;

(B) "Covered medical expenses" includes, at least, in the case of hospital room and board charges, the lesser of the dollar amount in Plan A and the average semiprivate room and board rate for the hospital in which the individual is confined and twice that amount for charges in an intensive care unit.

(xi) The conversion privilege required by this section shall, if the group insurance policy insures the employee or member for basic hospital or surgical expense insurance as well as major medical expense insurance, make available the plans of benefits set forth in paragraph (vi) of this subsection;

(xii) An insurer may:

(A) Provide the plans of benefits specified in paragraph (vi) of this subsection under one (1) policy;

(B) Instead of the plans of benefits set forth in paragraph (vi) of this subsection, provide a policy of comprehensive medical expense benefits without first dollar coverage, which policy shall conform to the requirements of subparagraph (vi)(B) of this subsection, except that an insurer electing to provide such a policy shall make available a low deductible option, not to exceed one hundred dollars ($100.00), a high deductible option between five hundred dollars ($500.00) and one thousand dollars ($1,000.00) and a third deductible option midway between the high and low deductible options;

(C) Offer alternative plans for group health conversion in addition to those required by this section;

(D) Provide group insurance coverage instead of issuing a converted individual policy.

(xiii) If coverage would be continued under the group policy on an employee following his retirement prior to the time he is or could be covered by Medicare, he may elect instead of continuation of group insurance, to have the same conversion rights as would apply if his insurance terminated at retirement by reason of termination of employment or membership;

(xiv) If the benefit levels required in paragraph (vi) of this subsection exceed the benefit levels provided under the group policy, the conversion policy may offer benefits which are substantially similar to those provided under the group policy instead of those required in paragraph (vi) of this subsection;

(xv) Maternity benefits may be included at the insured's option and may be subject to the preexisting conditions limitations as discussed under paragraph (v) of this subsection;

(xvi) A notification of the conversion privilege shall be included in each certificate of coverage;

(xvii) A converted policy which is delivered outside this state must be on a form which could be delivered in the other jurisdiction as a converted policy had the group policy been issued in that jurisdiction.

ARTICLE 3 - PREPAID HOSPITAL, MEDICAL-SURGICAL OR OTHER HEALTH SERVICE PLANS

26-22-301. Prepaid hospital, medical-surgical or other health service plans subject to provisions of code; exceptions.

(a) Any corporation which establishes, maintains or operates prepaid hospital, medical-surgical or other health service plans, or combination thereof, in which hospital, medical-surgical or other health service may be provided to its members or subscribers by hospitals or physicians with which the corporation has contracted for that purpose, is transacting insurance and subject to regulation and taxation as an insurer under this code.

(b) This section does not apply to company-operated or employee-operated organizations, not covered by hospital or sickness insurance, but formed and operated for the purpose of providing hospital or medical services supported or financed by dues paid to the associations by or on behalf of those who are employees or pensioners of the company.

(c) This section does not apply to a direct primary care agreement as defined in W.S. 26-1-104(a)(vi).

ARTICLE 4 - INSURANCE CONTINUATION FOR DEPENDENTS WITH DISABILITIES

26-22-401. Required provision of individual or group policy or contract.

(a) Any individual or group hospital or medical expense insurance policy or hospital service plan contract or medical service plan contract, delivered or issued for delivery in this state which provides that coverage of a dependent child of a policyholder or subscriber, or of an employee or other member of the covered group, as the case may be, terminates upon attainment of the limiting age for dependent children specified in the policy or contract, shall also provide in substance that attainment of the limiting age does not terminate the child's coverage while the child is and continues to be both:

(i) Incapable of self-sustaining employment by reason of intellectual disability or physical disability; and

(ii) Chiefly dependent upon the policyholder or subscriber, or the employee or other member of the covered group, as the case may be, for support and maintenance, provided proof of the incapacity and dependency is furnished to the insurer or hospital service plan corporation or medical service plan corporation by the policyholder or subscriber, or employee or other member of the covered group, as the case may be, within thirty-one (31) days of the child's attainment of the limiting age and subsequently as the insurer or corporation requires but not more frequently than annually after the two (2) year period following the child's attainment of the limiting age.

ARTICLE 5 - HEALTH CARE REIMBURSEMENT REFORM

26-22-501. Short title.

This article is known and may be cited as the "Health Care Reimbursement Reform Act of 1985".

26-22-502. Definitions.

(a) As used in this article:

(i) "Group" means any individual, partnership or corporation employing individuals in any occupation, or any labor union or other association representing such individuals if those individuals would qualify as an eligible group under W.S. 26-19-102(a)(i), (ii), (iii) or (viii) or any other number

of individuals organized or united for a common purpose including any purpose specified in this article;

(ii) "Health care services" means health care services or products rendered or sold by a provider within the scope of the provider's license or legal authorization and includes, but is not limited to, hospital, medical, surgical, dental, vision and pharmaceutical services or products;

(iii) "Insured" means an individual entitled to reimbursement for expenses of health care services under an agreement between a group and a provider or under a policy or subscriber contract issued or administered by an insurer;

(iv) "Insurer" means an insurance company or a health service corporation authorized in this state to issue policies or subscriber contracts which reimburse for expenses of health care services;

(v) "Provider" means an individual or entity licensed or legally authorized to provide health care services.

26-22-503. Policies with incentives or limits on reimbursement authorized; conditions.

(a) Notwithstanding any other provision of law to the contrary:

(i) Any provider may enter into a written agreement with any group or insurer relating to health care services which may be rendered to insureds, including amounts to be charged the insured for services rendered;

(ii) Any group or insured may contract with insurers to issue policies which:

(A) Include incentives for the insured;

(B) Limit reimbursement for health care services.

(iii) Before entering into any written agreement under paragraph (a)(i) of this section, the group or insurer shall establish terms and conditions to be required of any provider interested in entering into the agreement. In no event shall the established terms and conditions discriminate against any Wyoming provider nor shall any Wyoming provider willing to

meet the established terms and conditions be denied the right to enter into any written agreement;

(iv) This section shall not be construed to expand the scope of coverage as defined by any agreement.

(b) In no event may an insurer deny or limit reimbursement to an insured under this article on the grounds that the insured was not referred to the provider by a person acting on behalf of or under an agreement with the insurer.

(c) Any group may contract with an insurer, preferred provider organization or health maintenance organization for provision of medical services outside of Wyoming for the insureds of that group, provided the insureds are not restricted from utilizing any Wyoming provider who provides the same health care services.

26-22-504. Refusal to contract or compensate for covered services.

An insurer shall not refuse to contract with or compensate for covered services an otherwise eligible health care provider solely because that provider has in good faith communicated with one (1) or more of his current, former or prospective patients regarding the provisions, terms or requirements of the insurer's products as they related to the needs of that provider's patients.

26-22-505. Dental insurance; limitation on fee schedules for noncovered services; definition; applicability.

(a) No person or entity contracting with dentists to provide coverage or reimbursement for dental services shall require a dentist to provide services at a fee set by the contract, a policy or a certificate unless the services are covered services by the terms of the contract, policy or certificate.

(b) For purposes of this section, "covered services" means services reimbursable under the contract, policy or certificate, subject to customary contractual limitations on benefits including such items as deductibles, waiting periods, frequency limitations or charges over the benefit maximum.

(c) This section shall apply to contracts, policies or certificates issued, renewed, delivered or issued for delivery in this state on or after July 1, 2011.

26-22-506. Third party access to network contracts; dental care service plans; waiver prohibited; definitions.

(a) As used in this section:

(i) "Contracting entity" means any person that enters into a contract with a dental care provider for the delivery of dental care services;

(ii) "Covered person" means a policyholder, subscriber, enrollee or other person participating in a dental care service plan that provides for dental care services;

(iii) "Dental care provider" means any person licensed to practice dentistry in Wyoming and who provides dental care services pursuant to a dental care service plan;

(iv) "Dental care service plan" means a policy, contract, plan, certificate or agreement that provides for third party payment or prepayment of dental care services and that is delivered or issued for delivery by or through a dental carrier on a standalone basis;

(v) "Dental care services" means diagnostic, preventative, maintenance and therapeutic dental care. "Dental care services" shall not include services that are billed as medical expenses under a health benefit plan;

(vi) "Dental carrier" means a person subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, including an insurance company offering dental care service plans or any other person that provides a dental care service plan;

(vii) "Dentist agent" means a person that contracts with a dental care provider to establish an agency relationship for purposes of processing bills for services provided by the dental care provider under the terms and conditions of a contract between the dentist agent and a dental care provider. A contract between a dentist agent and a dental care provider may permit the dentist agent to submit bills, request reconsideration and receive reimbursement;

(viii) "Network contract" means a contract between a contracting entity and a dental care provider that specifies the rights and responsibilities of the contracting entity and provides for the delivery and payment of dental care services to a covered person;

(ix) "Third party" means a person, not including a covered person, who enters into a contract with a contracting entity to access the dental care services or contractual discounts of a network contract. "Third party" shall not include an employer or other group for whom the dental carrier or contracting entity provides administrative services;

(x) "Virtual credit card payment" means an electronic funds transfer where a dental care service plan, or a contracted vendor, issues a single-use series of numbers associated with the payment of dental care services performed by a dental care provider and chargeable up to a predetermined dollar amount, where the dental care provider is responsible for processing the payment by a credit card terminal or internal port. "Virtual credit card payment" includes only electronic or virtual credit card payments where no physical card is used and the single use electronic credit card expires upon payment processing.

(b) A contracting entity may grant a third party access to a network contract, or to a dental care provider's dental care service prices or contractual discounts provided pursuant to a network contract, if all of the following requirements are met:

(i) At the time the network contract is entered into, renewed or material modifications relevant to granting access to a third party are made, the dental carrier allows any dental care provider that is part of the dental carrier's provider network to choose to not participate in third-party access to the dental care provider's service prices and discounted rates;

(ii) The contracting entity allows the dental care provider to enter into a contract directly with the third party;

(iii) The network contract specifically states that the contracting entity may enter into an agreement with a third party to allow the third party to obtain the contracting entity's rights and responsibilities under the network contract as if the third party were the contracting entity. If the contracting entity is a dental carrier, the network contract shall specifically state that the dental care provider may choose not to participate in third-party access to the network

contract and that the dental care provider chose to participate in third-party access at the time the network contract was entered into or renewed;

(iv) The third party accessing the network contract agrees to comply with all of the network contract's terms and conditions;

(v) The contracting entity identifies to the dental care provider, in writing, all third parties participating in the network contract as of the date the network contract is entered into or renewed;

(vi) The contracting entity provides a list of all third parties participating in the network contract on the contracting entity's website. The contracting entity shall update and provide an updated list of third parties on its website not less than every ninety (90) days;

(vii) The contracting entity notifies a dental care provider under the network contract at least thirty (30) days prior to a new third party leasing or purchasing the network contract;

(viii) The contracting entity requires a third party to identify, for all remittance advice or explanations of payments under which a discount applies, the source of the discount. This paragraph shall not apply to an electronic transaction mandated by the federal Health Insurance Portability and Accountability Act of 1996, P.L. 104-191;

(ix) A third party's right to a dental care provider's discounted rate is terminated as of the termination date of the network contract;

(x) In the adjudication of any claim under the network contract, the contracting entity makes available to the dental care provider a copy of the network contract not later than thirty (30) days after a request for the network contract is received.

(c) A contracting entity shall not cancel or terminate a contractual relationship with, or refuse to contract with, a dental care provider on the grounds that the dental care provider refuses to allow access by a third party to the dental care services and discounted rates of the dental care provider.

(d) This section shall not apply if access to a provider network contract is granted to a dental carrier or an entity operating in accordance with the same brand licensee program as the contracting entity or to an entity that is an affiliate of the contracting entity. A list of the contracting entity's affiliates shall be made available to a provider on the contracting entity's website.

(e) No dental care provider shall be bound by, or required to perform, dental care services under a network contract for which access has been granted to a third party in violation of this section.

(f) A dental care service plan shall not require payments to be made to dental care providers solely by virtual credit card payments.

(g) A dental care service plan, when initiating payments to a dental care provider through a virtual credit card payment or when changing to virtual credit card payments if the dental care provider consents, shall do all of the following:

(i) Notify the dental care provider of any fees associated with each payment method available from the dental care service plan;

(ii) Inform the dental care provider of the available options for methods of payment and provide clear instructions to the dental care provider for the selection of an alternative payment method that does not impose fees.

(h) If a dental care provider opts out of a method of payment that is offered by a dental care service plan, that decision remains in effect unless the dental care provider opts back into the prior method of payment or a new contract is executed.

(j) A dental care service plan that transmits payments to a dental care provider in accordance with the standards of 45 C.F.R. §§ 162.1601 and 162.1602 shall not charge a fee solely for the transmission of the payment to the dental care provider unless the dental care provider has consented to payment of the fee. When transmitting a national automated clearinghouse payment, a dentist agent may charge a reasonable fee related to bank transmittal, transaction management, data management, portal services and other value added services associated with the transmission of the payment.

(k) The requirements of this section shall not be waived unless knowingly and voluntarily waived by the party bound by the contract.

CHAPTER 23 - CASUALTY INSURANCE, SURETY INSURANCE AND TITLE INSURANCE

ARTICLE 1 - PROPERTY INSURANCE CONTRACTS

26-23-101. Overinsurance prohibited.

(a) No person shall buy insurance on property within this state for an amount which, together with any existing insurance, exceeds the fair value of the property or of the interest of the insured therein. This provision does not apply as to insurance of replacement value.

(b) Anyone who willfully violates this section is subject to the penalties provided in W.S. 26-1-107.

26-23-102. Adjuster's reports of overinsurance and causes of fire; reports deemed privileged communications.

(a) Any adjuster who investigates any property loss claim in this state shall report to the commissioner in writing any overinsurance of the property he discovers.

(b) Any adjuster who investigates any property fire loss in this state shall report in writing to the commissioner the origin and cause of the fire, so far as he can reasonably ascertain them, together with any circumstances which in his opinion may indicate fraud or attempted fraud.

(c) Any report submitted to the commissioner under this section, together with any accompanying information, document, record or statement, is an absolutely privileged communication. The report may be disclosed as authorized by and in accordance with the provisions of W.S. 26-2-113(d).

26-23-103. Return of excess premium in certain cases of total destruction.

If the insured property is totally destroyed and the total amount of loss is less than the total amount insured thereon as to the hazard causing the loss, the insurer shall return to the insured at the time of payment of the loss the amount of

premiums paid under the policy then in force for the excess of insurance over the fair value of the property at the time of the loss. This section does not apply to insurance of replacement value.

26-23-104. Terms of policies; extension.

(a) No insurer shall issue a policy insuring property in this state for a term longer than five (5) years.

(b) The term of any such policy may be extended by certificate as provided in W.S. 26-15-121.

26-23-105. Exemptions.

W.S. 26-23-101(a), 26-23-102 and 26-23-103 do not apply to insurance on stocks of merchandise or property of fluctuating values, if the reduced rate contribution clause is made a part of the policy. This chapter does not apply to wet marine and transportation insurance.

26-23-106. Use of insurance support organizations limited.

This section shall apply if an insurer uses for underwriting purposes for insurance policies information from a report provided by, or database maintained by, an insurance support organization, or consumer reporting agency, related to the premises that is the subject of the application or to the person applying for insurance. Failure of the insurer, within forty-five (45) calendar days of issuing a binder, to act upon the information referenced in this section precludes the insurer from declining insurance coverage or terminating a binder of insurance coverage based on the information. Notwithstanding any other law, an insurer may decline or terminate insurance coverage based on the condition of the premises as determined through a physical inspection of the premises. This section applies only to homeowner's insurance and does not apply to a policy renewal.

26-23-107. Cancellation and nonrenewal of homeowner's insurance policies for natural causes restricted.

(a) No homeowner's insurance policy shall be denied renewal as a result of a single claim within a three (3) year period arising from natural causes.

(b) No homeowner's insurance policy shall be cancelled during its term as a result of any claim arising from natural causes.

(c) As used in this section "natural cause" means an act occasioned exclusively by the violence of nature where all human agency is excluded from creating or contributing to the cause of the damage or injury.

(d) Any insurer which violates the provisions of this section shall be subject to the procedures and penalties provided under this code. Following the procedures in this code, the commissioner may order the reinstatement, with no lapse in coverage, of any policy cancelled or nonrenewed in violation of this section.

26-23-108. Restrictions on underwriting for homeowner policies.

(a) No insurer shall cancel, refuse to renew or offer to renew at a higher premium a homeowner's insurance policy based in any manner upon the claims history of a named insured unless the claims history excludes customer inquiries. Customer inquiries are defined as telephone calls or other requests for information made by the named insured or a person who would be a named insured under the policy, that reference the terms, conditions or coverage afforded under an insurance contract and do not result in claims being filed or paid.

(b) Any insurer which violates the provisions of this section shall be subject to the procedures and penalties provided under this code. Following the procedures in this code, the commissioner may order the reinstatement, with no lapse in coverage, of any policy cancelled or nonrenewed in violation of this section. If the commissioner finds a policy was renewed at a higher premium in violation of this section he may order the return of any unauthorized increase in premium together with interest at a rate of ten percent (10%) per year.

26-23-109. Insurance coverage for real property subject to transfer on death deeds.

(a) For transfers on and after July 1, 2023, upon transfer of title to an interest in real property after the death of the owner pursuant to a transfer on death deed under W.S. 2-18-103, any insurance coverage on the property transferred shall be extended to cover losses to the property as if the grantee

beneficiary designated in the transfer on death deed was a named insured.

(b) The extension of insurance coverage to the grantee beneficiary shall continue for sixty (60) days after the transfer of title under subsection (a) of this section.

(c) Not later than sixty (60) days after the transfer of title under subsection (a) of this section, each grantee beneficiary shall notify the insurer of a transfer in title under this section and shall provide a current address for the insurer to contact the grantee beneficiary. Failure to provide notice as required under this subsection shall not negate the extended insurance coverage required under this section.

(d) Not less than twenty (20) business days before the end of the period specified in subsection (b) of this section and if the grantee beneficiary has provided the notice required under subsection (c) of this section, the insurer shall send notice in writing to the grantee beneficiary who has received title to the interest in real property under W.S. 2-18-103 stating that insurance coverage for the property will terminate on the date specified in subsection (b) of this section. Any notice sent to a grantee under this subsection shall include the exact date on which coverage for the grantee will cease.

ARTICLE 2 - CASUALTY AND SURETY INSURANCE CONTRACTS

26-23-201. Casualty and surety contracts subject to provisions of code.

(a) The following insurance contracts covering subjects of insurance resident, located or to be performed in this state are subject to the applicable provisions of chapter 15 and to other applicable provisions of this code:

(i) Casualty insurance contracts; and

(ii) Surety insurance contracts.

ARTICLE 3 - TITLE INSURANCE

26-23-301. Short title.

This article is known and may be cited as the "Wyoming Title Insurance Act".

26-23-302. Applicability of article; construction with other laws.

(a) This article applies to all title insurers, title insurance rating organizations, title agents, applicants for title insurance, title insurance policyholders, and all persons engaged in title insurance transactions in this state.

(b) Except as otherwise expressly provided in this article, and except where the context otherwise requires, all provisions of this code applying to insurance and insurance companies generally apply to title insurance and title insurance companies.

(c) Nothing in this article shall be construed to authorize the practice of law by any person who is not admitted to practice law in this state nor shall it be construed to authorize the commissioner to regulate the practice of law.

26-23-303. Definitions.

(a) As used in this article:

(i) "Alien title insurer" means any title insurer incorporated or organized under the laws of any foreign nation or any province or territory thereof;

(ii) "Applicant" means a person, whether or not a prospective insured, who applies to a title insurer or title agent for a title insurance policy and who, at the time of the application, is not a title agent;

(iii) "Approved attorney" means an attorney at law who is not an agent or employee of a title insurer and whose certification as to status of title a title insurer is willing to accept as the basis for issuance of its title insurance policy;

(iv) "Associate" means any:

(A) Business organized for profit in which a producer of title business is a director, officer, partner, employee or owner of five percent (5%) or more of the equity capital thereof;

(B) Employee of a producer of title business;

(C) Franchisor or franchisee of a producer of title business;

(D) Spouse, parent or child of a producer of title business who is a natural person;

(E) Person, other than a natural person, that controls, is controlled by or is under common control with a producer of title business; or

(F) Person with whom a producer of title business or any associate of such producer has any agreement, arrangement or understanding, or pursues any course of conduct, the purpose or substantial effect of which is to evade the provisions of this article.

(v) "Charge" means any fee billed by a title agent or title insurer or both for the performance of services, other than fees that fall within the definition of premium in paragraph (a)(xiv) of this section and includes but is not limited to fees for document preparation, fees for the handling of escrows, settlements or closings and fees for services commenced but not completed. "Charge" does not include fees collected by a title insurer or title agent in an escrow, settlement or closing when the fees are limited to the amount billed for services rendered by an entity independent of the title insurer or title agent;

(vi) "Controlled business" means any portion of a title insurer's or title agent's business of title insurance in this state, referred to it by any producer of title business or by any associate of such producer, if the producer of title business, the associate, or both, have a financial interest in the title insurer or title agent to which business is referred;

(vii) "Domestic title insurer" means a title insurer organized under the laws of this state;

(viii) "Escrow, settlement or closing fee" means the consideration for supervising the actual execution, delivery or recording of transfer and lien documents and for disbursing funds;

(ix) "Financial interest" means any interest that entitles the holder in any manner to five percent (5%) or more of the net profits or net worth of the entity in which the interest is held;

(x) "Foreign title insurer" means any title insurer organized under the laws of any other state of the United States, the District of Columbia or any other jurisdiction of the United States;

(xi) "Gross operating revenue" means all premiums received by a title insurer or title agent;

(xii) "Net retained liability" means the total liability retained by a title insurer for a single risk, after taking into account the deduction for ceded liability, if any;

(xiii) "Person" means any natural person, partnership, association, cooperative, corporation, trust or other legal entity;

(xiv) "Premium" means fees for:

(A) Issuing a title insurance policy, including any service charge administration fee for the issuance of a title insurance policy;

(B) Abstracting, searching and examining title when conducted or performed in contemplation of or in conjunction with the issuance of a title insurance policy;

(C) Preparing or issuing preliminary reports, property profiles, commitments, binders or like products;

(D) Assuming liability under a contract of reinsurance.

(xv) "Producer of title business" or "producer" means any person, including any officer, director or owner of five percent (5%) or more of the equity or capital of any person engaged in this state in the trade, business, occupation or profession of:

(A) Buying or selling interests in real property;

(B) Making loans secured by interests in real property; or

(C) Acting as broker, agent, representative or attorney of a person who buys or sells any interest in real

property or who lends or borrows money with such interest as security.

(xvi) "Refer" means to direct or cause to be directed or to exercise any power or influence over the direction of title insurance business, whether or not the consent or approval of any other person is sought or obtained with respect to the referral;

(xvii) "Report", subject to the stated exceptions set forth therein, issued prior to the issuance of a policy, means a "preliminary report", "commitment", or "binder" and constitutes a statement of the terms and conditions upon which the insurer is willing to issue its policy but is not a title policy. Neither a title policy nor a report issued prior to the issuance of a title insurance policy is an abstract of title;

(xviii) "Single risk" means the insured amount of any title insurance policy, except that if two (2) or more title insurance policies are issued simultaneously covering different estates in the same real property, "single risk" means the sum of the insured amounts of all such title insurance policies. Any title insurance policy insuring a mortgage interest a claim payment under which reduces the insured amount of a fee or leasehold title insurance policy shall be excluded in computing the amount of a single risk to the extent that the insured amount of the mortgagee title insurance policy does not exceed the insured amount of the fee or leasehold title insurance policy;

(xix) "Title agent" or "agent" means any person authorized in writing by a title insurer to do any of the following but does not include approved attorneys, officers or employees of a title insurer:

(A) Solicit title insurance business;

(B) Collect premiums;

(C) Determine insurability in accordance with underwriting rules and standards prescribed by the title insurer; or

(D) Issue policies of the title insurer.

(xx) "Title insurance business" or "business of title insurance" means:

(A) Issuing as insurer or offering to issue as insurer a title insurance policy;

(B) Transacting or proposing to transact by a title insurer or title agent any of the following activities when conducted or performed in contemplation of the issuance of a title insurance policy:

(I) Soliciting or negotiating the issuance of a title insurance policy;

(II) Guaranteeing, warranting or otherwise insuring the correctness of title searches;

(III) Handling of escrows, settlements or closings;

(IV) Execution of title insurance policies;

(V) Effecting contracts of reinsurance;

(VI) Abstracting, searching or examining titles; or

(VII) Doing or proposing to do any business in substance equivalent to any of the businesses specified in subdivisions (I) through (VI) of this subparagraph in a manner designed to evade the provisions of this article.

(xxi) "Title insurance policy" or "policy" means a contract wherein, subject to the stated terms and conditions, a title insurer insures, guarantees or indemnifies owners of real or personal property or the holders of liens or encumbrances thereon or others interested therein against loss or damage suffered by reason of:

(A) Defects in, adverse claims, liens or encumbrances in the title to the stated property;

(B) Unmarketability of the title to the stated property;

(C) Guaranteeing, warranting or otherwise insuring by a title insurance company the correctness of searches relating to the title to property;

(D) Defects in the authorization, execution or delivery of an encumbrance upon such property;

(E) The insuring by a title insurance company the validity and enforceability of evidences of indebtedness secured by an encumbrance upon the title or interest in such property;

(F) The invalidity, unenforceability or loss of priority of an insured mortgage resulting from a change in rate of interest or principal balance, or both, which change is in accordance with the provisions of the insured mortgage.

(xxii) "Title insurer" or "insurer" means a company organized under laws of this state for the purpose of transacting as insurer the business of title insurance and any foreign or alien title insurer engaged in this state in the business of title insurance as insurer;

(xxiii) "Title plant" means a set of records in which an entry has been made of documents or matters imparting constructive notice under the law of matters affecting title to real property or any interest therein or encumbrance thereon, which have been filed or recorded in the jurisdiction for which the title plant is maintained.

26-23-304. Corporate form required.

No person other than a domestic, foreign or alien title insurer organized on the stock plan and licensed under this code shall transact title insurance business as an insurer in this state.

26-23-305. Title insurers; authorized activities.

(a) Each title insurer may:

(i) Engage in the title insurance business in this state if licensed to do so by the commissioner;

(ii) Subject to the limitations of this article, provide any other service related or incidental to the sale and transfer of property; or

(iii) Conduct its operations on a direct basis through a branch office located within the state without using a title agent.

26-23-306. Limitations on powers.

(a) An insurer that transacts any class or kind of insurance other than title insurance is not eligible for a license to transact the business of title insurance in this state, nor for the renewal thereof, nor shall title insurance be transacted, underwritten or issued by any insurer transacting or licensed to transact any other kind of insurance.

(b) An insurer shall not engage in the business of guaranteeing payment of the principal or the interest of bonds or mortgages.

(c) An insurer shall not engage in the business of guaranteeing the obligations of other persons other than issuing insured closing letters covering its agents in the normal course of business.

26-23-307. Single risk limitation.

(a) The net retained liability of a title insurer for a single risk on property located in this state, whether assumed directly or as reinsurance, shall not exceed fifty percent (50%) of the sum of its total surplus to policyholders and reinsurance reserve, less the value assigned to title plants, as shown in the insurer's most recent annual statement on file in the commissioner's office.

(b) The commissioner may waive the limitation of this section for a particular risk upon application of the insurer and for good cause shown.

26-23-308. Underwriting standards; record retention.

(a) No title insurance policy as to property in this state shall be written unless it is based upon adequate evidence of the current condition of title certified in writing as of the date of the policy by a person duly authorized under W.S. 33-2-101 to act as a title abstractor in the county where the property is situated, or based upon the opinion of an attorney authorized to practice law in this state as to the condition of the title following a review by the attorney of pertinent title records or abstracts. Evidence of the examination of title and determination of insurability shall be preserved and retained in the files of the title insurer or its title agent for a period of not less than fifteen (15) years after the title insurance policy has been issued. Instead of retaining the original

evidence, the title insurer or title agent, in the regular course of business, may establish a system whereby all or part of the evidence is recorded, copied or reproduced by any process that accurately and legibly reproduces or forms a durable medium for reproducing the contents of the original. This subsection does not apply to a title insurer:

(i) Assuming liability through a contract of reinsurance; or

(ii) Acting as coinsurer if one (1) of the other coinsuring title insurers has complied with this section.

(b) Except as allowed by regulations the commissioner promulgates, no title insurer or title agent shall knowingly issue any title insurance policy or commitment to insure without showing all outstanding, enforceable, recorded liens or other interests against the property, title to which is to be insured.

26-23-309. Reinsurance reserve.

(a) A domestic title insurer shall establish and maintain a reinsurance reserve computed in accordance with this section, and all sums attributed to that reserve are considered and constitute unearned portions of the original premiums. This reserve shall be reported as a liability of the title insurer in its financial statements.

(b) The reinsurance reserve shall be maintained by the title insurer for the protection of holders of title insurance policies. Except as provided in this section, assets equal in value to the reinsurance reserve are not subject to distribution among creditors or stockholders of the title insurer until all claims of policyholders or claims under reinsurance contracts have been paid in full, and all liability on the policies or reinsurance contracts has been paid in full and discharged or lawfully reinsured.

(c) A foreign or alien title insurance company licensed to transact title insurance business in this state shall maintain at least the same reserves on title insurance policies issued on properties located in this state as are required of domestic title insurance companies, unless the laws of the jurisdiction of domicile of the foreign or alien title insurance company require a higher amount.

(d) The reinsurance reserve shall consist of:

(i) The amount of the reinsurance reserve on May 27, 1983; and

(ii) A sum equal to twenty cents ($.20) for each one thousand dollars ($1,000.00) of net retained liability under each title insurance policy on a single risk written on properties located in this state written after May 27, 1983.

(e) Amounts placed in the reinsurance reserve in any year in accordance with paragraph (d)(ii) of this section shall be deducted in determining the net profit of the title insurer for that year.

(f) A title insurer shall release from the reinsurance reserve a sum equal to the appropriate amount as set forth in the most recent National Association of Insurance Commissioners' accounting practices and procedures manual. The amount of the reinsurance reserve or similar unearned premium reserve maintained before July 1, 2001, shall be released in accordance with the law in effect at the time such reserves became effective.

26-23-310. Use of reinsurance reserve on liquidation, dissolution or insolvency.

(a) If a domestic title insurer becomes insolvent, is in the process of liquidation of dissolution or is in the commissioner's possession:

(i) The amount of the assets of the title insurance company equal to the reinsurance reserve then remaining may be used by or with the commissioner's written approval to pay for reinsurance of the title insurer's liability upon all outstanding title insurance policies or reinsurance agreements to the extent to which claims for losses by the holders thereof are not then pending. The balance of assets, if any, equal to the reinsurance reserve may then be transferred to the title insurer's general assets;

(ii) The assets net of the reinsurance reserve shall be available to pay claims for losses sustained by holders of title insurance policies then pending or arising up to the time reinsurance is effected. If claims for losses exceed the title insurer's other assets those claims, when established, shall be paid pro rata out of the surplus assets attributable to the reinsurance reserve, to the extent of the surplus, if any.

(b) If reinsurance is not obtained, assets equal to the reinsurance reserve and assets constituting minimum capital, or so much as remains thereof after outstanding claims have been paid, constitute a trust fund to be held and invested by the commissioner for twenty (20) years, out of which claims of policyholders shall be paid as they arise. The balance, if any, of the trust fund, at the expiration of twenty (20) years, shall revert to the general assets of the title insurer.

26-23-311. Loss and loss expense reserve.

(a) All title insurers licensed in this state shall establish and maintain reserves against unpaid losses and loss expenses.

(b) Upon receiving notice from or on behalf of the insured of a title defect in or lien or adverse claim against the title of the insured that may result in a loss or cause expense to be incurred in the proper disposition of the claim, the title insurer shall determine the amount to be added to the reserve, which amount shall reflect a careful estimate of the loss or loss expense likely to result by reason of the claim.

(c) Reserves required under this section may be revised from time to time and shall be redetermined at least once each year.

26-23-312. Reinsurance.

(a) A title insurer may obtain reinsurance for all or any part of its liability under one (1) or more of its title insurance policies or reinsurance agreements and may also reinsure title insurance policies issued by other title insurers on risks located in this state or elsewhere. Reinsurance on policies issued on properties located in this state must be obtained from title insurers licensed to transact title insurance business in this state.

(b) Upon application by a title insurer, the commissioner may permit the insurer to obtain reinsurance from a title insurer not licensed in this state if:

(i) The title insurer is unable to obtain reinsurance from a title insurer licensed in this state; and

(ii) The capital and surplus of the unlicensed title insurer meet the requirements for licensed companies under this code.

26-23-313. Investments.

(a) Except as otherwise expressly provided in this section, the general investment provisions of chapter 7 of this code apply to all domestic title insurers.

(b) A domestic title insurer may invest and have invested funds in an amount not exceeding its surplus to policyholders or three hundred thousand dollars ($300,000.00), whichever is the larger sum, in title plants and equipment and in stocks of abstract companies.

(c) Investment in plants, equipment and abstract company shares authorized by this section shall not be credited against the insurer's required reinsurance reserves.

(d) Any investment of a domestic title insurer acquired before May 27, 1983, and which, under this section, would be considered ineligible as an investment on that date shall be disposed of before May 27, 1985. The commissioner, upon application and proof that forced sale of any such investment would be contrary to the best interests of the title insurer or its policyholders, may extend the period for disposal of the investment for a reasonable time.

26-23-314. Conditions for providing escrow, closing or settlement services, or maintaining title indemnification accounts.

(a) A title insurer or title agent may engage in the escrow, settlement, or closing business, or any combination of such businesses, and operate as an escrow, settlement, or closing agent, provided that:

(i) Funds deposited in connection with any escrow, settlement, closing or title indemnification shall be deposited in a separate fiduciary trust account or accounts in a bank or other financial institution insured by an agency of the federal government. These funds are the property of the person or persons entitled thereto under the provisions of the escrow, settlement, closing or title indemnification and shall be segregated by escrow, settlement, closing or title indemnification in the records of the title insurer or title

agent. Those funds are not subject to any debts of the title insurer or title agent and shall be used only in accordance with the terms of the individual escrow, settlement, closing or title indemnification under which the funds were accepted;

(ii) Interest received on funds deposited with the title insurer or title agent in connection with any escrow, settlement, closing or title indemnification shall be paid to the depositing party unless the instructions provide otherwise;

(iii) The title insurer or title agent shall maintain separate records of all receipts and disbursements of escrow, settlement, closing or title indemnification funds.

26-23-315. Identification of title agents.

A title insurer shall provide to the commissioner on an annual basis a list of all of its title agents within this state.

26-23-316. Title agents; license required; requirements as to license.

(a) No person shall act as a title agent unless licensed in accordance with this article.

(b) No license shall be issued to, continued or permitted to exist for any person to act as a title agent unless the person:

(i) Is at least eighteen (18) years of age;

(ii) Is a bona fide resident of and resides within this state or any other state which has entered into a reciprocal title agent licensing agreement with the commissioner;

(iii) Is appointed as a title agent by a title insurer, subject to the issuance of the title agent's license;

(iv) Passes an examination given by the commissioner or any testing service selected by the commissioner covering the search and examination of title to real property, insurance principles relating to title insurance and the fiduciary duties and procedures of escrows, closings and settlements of real estate transactions.

(c) Any person, other than a natural person, to whom a title insurance agent's license is issued shall designate to the commissioner those natural persons who are or will be exercising the powers and performing the duties of the title insurance agent. The designated individuals are subject to paragraphs (b)(i) and (iii) of this section. Persons performing only clerical functions are not subject to the requirements of subsection (b) of this section.

(d) Any person, other than a natural person, to whom a title insurance agent's license is issued shall demonstrate that each natural person designated to exercise the powers and perform the duties of the title insurance agent meets the requirements of subsection (b) of this section.

26-23-317. Title agents; application for license.

(a) Application for a license to act as a title agent shall be made in writing in the form and manner the commissioner prescribes. An application fee, as provided by W.S. 26-4-101, shall be paid at the time of application.

(b) The application is a continuing one, and any prospective licensee or licensees shall inform the commissioner promptly if any information set forth in the application changes or is no longer accurate, or if any other relevant information regarding the application arises after the original application.

26-23-318. Title agents; issuance of license; expiration; renewal.

(a) The commissioner shall issue a license to act as a title agent to any person if:

(i) The prospective licensee files an application pursuant to W.S. 26-23-317;

(ii) The prospective licensee meets the requirements of W.S. 26-23-316; and

(iii) The prospective licensee provides the commissioner with evidence of financial responsibility in the form and in a minimum amount the commissioner requires by regulation.

(b) Each individual title agent's license expires on the last day of the month of the licensee's birthday in the second

year following the issuance or renewal of the license, and may be renewed if prior to the expiration of his license a written request for continuation of the license is made to the commissioner on forms prescribed by the commissioner, the continuation fee set forth in W.S. 26-4-101 is paid, continuing education requirements are met by the due date and the licensee remains in compliance with all other applicable provisions of this code. An individual title agent who allows the license to lapse may, within twelve (12) months from the due date of the continuation fee, reinstate the same license without the necessity of passing a written examination, however, a penalty equal to the amount of the continuation fee shall be required in addition to the continuation fee for any continuation request received after the due date.

(c) Each title agent license issued to a business entity expires on the last day of the month in which the license was effective in the second year following the issuance or renewal of the license and may be renewed if prior to the expiration of the license, a written request for continuation of the license is made to the commissioner on forms prescribed by the commissioner, the continuation fee set forth in W.S. 26-4-101 is paid and the licensee remains in compliance with all other provisions of this code. A business entity title agent that allows the license to lapse may, within twelve (12) months from the due date of the continuation fee, reinstate the same license, however, a penalty equal to the amount of the continuation fee shall be required in addition to the continuation fee for any continuation request received after the due date.

26-23-319. Title agents; records.

(a) A title agent shall keep books of account and records and vouchers pertaining to any business transacted under this article. All records shall be maintained in a manner that the commissioner may readily ascertain from time to time whether the title agent has complied with all applicable provisions of this article.

(b) The commissioner, at any time during normal business hours, may examine, audit and inspect books and records maintained by title agents under this article.

26-23-320. Title agents; report of claims.

(a) A title agent shall immediately report every loss claim to the title insurer that issued the policy against which the claim is presented.

(b) No title agent shall indemnify or pay the claim of any insured.

26-23-321. Title agents; refusal, suspension or revocation of license; fine instead of suspension.

(a) In addition to any other grounds stated in this article, the commissioner may refuse to license any person as a title agent, or may suspend a title agent's license, after providing due notice and an opportunity to be heard, upon a finding that the person:

(i) Fails to meet the qualifications for licensure under this code;

(ii) Has violated any provision of this code or any rule or regulation of the commissioner;

(iii) Has made a material misstatement in an application for a title insurance agent's license or has obtained a title insurance agent's license by fraud or willful misrepresentation;

(iv) Has misappropriated or converted to his own use funds belonging to applicants, insureds, title insurers, escrow participants or others;

(v) Has intentionally misrepresented the terms of a title insurance policy to any applicant or policyholder or has misrepresented material facts to, concealed material facts from or made false statements to any party to an escrow, settlement or closing transaction;

(vi) Has in the conduct of his affairs under his title insurance agent's license, used fraudulent, coercive or dishonest practices or has shown himself to be incompetent, untrustworthy, financially irresponsible or a source of injury and loss to the public; or

(vii) Has aided, abetted or assisted another person in violating this article or any rule or regulation promulgated under this article.

(b) The commissioner may revoke the title agent's license of any person convicted by final judgment of a felony that relates to the title insurance profession or to the ability to practice as a title insurance agent.

(c) In addition to or without imposing the penalties specified in subsections (a) and (b) of this section, the commissioner may impose a fine in an amount not to exceed two thousand five hundred dollars ($2,500.00) for each violation of this section or of any rule or regulation promulgated under this section.

(d) Any of the penalties provided under this section may be imposed on a title agent other than a natural person for action of individuals designated by that insurance agent.

26-23-322. Rebates and inducements prohibited.

(a) No title insurer or title agent shall:

(i) Pay in any manner to any person any commission, any part of its premiums, fees or other charges or any other consideration as inducement or compensation for the referral of title business or for performance of any escrow or other service by the title insurer or title agent;

(ii) Issue any title insurance policy or perform any service in connection with any transaction in which it has paid or intends to pay any commission, rebate or inducement which it knows to be in violation of this section.

(b) No person shall knowingly receive or accept in any manner, any commission, rebate or inducement referred to in subsection (a) of this section.

(c) Nothing in this section shall be construed as prohibiting reasonable payments, other than for the referral of title insurance business, for services actually rendered to either a title insurer or a title agent in connection with title insurance business.

26-23-323. Division of premiums and charges.

(a) Nothing in this article shall be construed as prohibiting the division of premiums and charges between or among a title insurer and its title agent, two (2) or more title insurers, one (1) or more title insurers and one (1) or more

title agents or two (2) or more title agents, provided the division of premiums and charges does not constitute:

(i) An unlawful rebate or inducement under this article; or

(ii) Payment of a forwarding fee or finder's fee.

26-23-324. Favored title agent or insurer.

(a) No producer or other person shall require in any manner as a condition, agreement or understanding to selling or furnishing any other person any loan or extension thereof, credit, sale, property, contract, lease or service, that such other person shall place any contract of title insurance of any kind through any particular title agent or title insurer. No title agent or title insurer shall knowingly participate in any such prohibited plan or transaction. No person shall fix a price charged for such thing or service, or discount from or rebate upon price, on the condition, agreement or understanding that any title insurance is to be obtained through a particular title agent or title insurer.

(b) Any producer or other person who violates this section, or any title insurer or title agent who accepts an order for title insurance knowing that it is in violation of this section, in addition to any other action which may be taken by the regulatory authority having jurisdiction, is subject to a fine by the commissioner in an amount equal to five (5) times the premium for the title insurance.

(c) The commissioner may invoke the aid of the courts in enforcing any fines imposed under this section.

26-23-325. Premium rate standards.

(a) Premium rates shall not be inadequate, excessive or unfairly discriminatory.

(b) Rates are excessive if in the aggregate they are likely to produce a long run profit that is unreasonably high in relation to the riskiness of the class of business, or if expenses are unreasonably high in relation to the services rendered.

(c) Rates are inadequate if they are clearly insufficient, together with investment income attributable to them, to sustain

projected losses and expenses, or if the continued use of such rates will have the effect of substantially lessening competition or the effect of tending to create a monopoly.

(d) Premium rates are unfairly discriminatory if the premium charged for any classification is not reasonably related to the services performed or the risks assumed by the insurer, provided within rate classifications, premiums, to a reasonable degree, may be less in the case of smaller insurances and the excess may be charged against larger insurances without rendering the rate unfairly discriminatory.

(e) In making or reviewing rates, consideration shall be given to past and prospective loss experience, to exposure to loss, to underwriting practice and judgment, to past and prospective expenses including amounts paid to or retained by title agents, to investment income, to a reasonable margin for profit and contingencies and to any other relevant factors both within and outside of this state.

(f) The commissioner may promulgate rules or regulations setting forth guidelines for evaluation of rates. These regulations may include consideration of:

(i) Costs of underwriting risks assumed by the insurer;

(ii) Amounts paid to or retained by title agents;

(iii) Operating expenses of the insurer other than underwriting and claims expenses;

(iv) Payment of claims and claim related expenses;

(v) Investment income;

(vi) Reasonable profit;

(vii) Premium taxes; and

(viii) Any other factors the commissioner deems relevant.

26-23-326. Premium rate schedules.

(a) A title insurer shall file with the commissioner the premium rate schedules it proposes to use in this state. If the

commissioner finds in his review of a filing that it does not violate W.S. 26-23-325, he shall approve the schedule within thirty (30) days of filing. Prior to such approval, the commissioner may conduct public hearings with respect to the filing. Filings that the commissioner fails to approve or disapprove within thirty (30) days of filing are approved. Upon notice to the title insurer, the period for review of rate filing may be extended for an additional thirty (30) days. If within the waiting period or extension thereof the commissioner finds that the filing does violate W.S. 26-23-325, he shall give written notice of disapproval of the filing to the insurer or rating organization which made the filing, specifying therein in what specific respects he finds the filing violates W.S. 26-23-325 and stating that the filing shall not become effective.

(b) If at any time after the approval of filing, the commissioner believes that the filing does not meet the requirements of this section or is otherwise contrary to law, or if any party having an interest in the filing makes a written complaint to the commissioner setting forth specific and reasonable grounds for the complaint, or if any insurer, upon notice of disapproval by the commissioner of a filing pursuant to this section, requests, the commissioner shall hold a hearing within thirty (30) days and shall give written notice of the hearing to all parties in interest. The commissioner may confirm, modify, change or rescind any previous action, if warranted by the facts shown at the hearing.

(c) No title insurer or title agent shall use or collect any premium after May 27, 1983, except in accordance with the premium rate schedule filed with and approved by the commissioner as required by this section. The commissioner may provide by regulation for interim use of premium rate schedules in effect prior to May 27, 1983.

26-23-327. Publication of schedules of premiums and charges.

(a) Each title insurer and title agent shall print and make available to the public schedules of its currently effective premiums and charges.

(b) The schedules shall:

(i) Be dated to show the date the premiums and charges became effective;

(ii) Be kept available to the public during normal business hours in each office of the title insurer or title agent in this state; and

(iii) Set forth the total premium and charge for each type of title insurance policy or service issued or provided by the title insurer or title agent either by stating the premium or charge for each type of title insurance policy in given amounts of coverage or for each service, or by stating the premium or charge rate per unit amount of coverage, or by a combination of the two.

(c) Each title insurer and title agent shall keep a complete file of its schedules of premium and charges and of all changes and amendments to those schedules until at least five (5) years after they cease to be in effect.

26-23-328. Form filing.

(a) A title insurer shall file with the commissioner any forms it proposes to use in this state, including:

(i) Title insurance policies, including standard form endorsements;

(ii) "Preliminary reports", "commitments", "binders" or any other reports issued prior to the issuance of a title insurance policy.

(b) If the commissioner finds in his review of a filing that it does not violate W.S. 26-23-329, he shall approve the form within thirty (30) days of filing. Prior to such approval, the commissioner may conduct public hearings with respect to the filing. Filings that the commissioner has failed to approve or disapprove within thirty (30) days of filing are deemed approved. Upon notice to the title insurer, the period for review of a form filing may be extended for an additional thirty (30) days. If, within the waiting period or extension thereof, the commissioner finds that the filing does violate W.S. 26-23-329, he shall give written notice of disapproval of the filing to the insurer or rating organization which made the filing, specifying therein in what specific respects he finds the filing violates W.S. 26-23-329 and stating that the filing shall not become effective.

(c) A title insurer need not file reinsurance contracts and agreements.

(d) No title insurer may issue, directly or through a title agent, any policy after May 27, 1983, unless the policy form has been approved pursuant to this section. The commissioner may provide by regulation for interim use of forms in effect prior to May 27, 1983.

26-23-329. Form standards.

(a) The commissioner shall approve any form filed under W.S. 26-23-328 only if the form:

(i) Is written in simple language logically and clearly arranged and is understandable to a person of normal intelligence without special insurance or legal knowledge or training;

(ii) Does not contain or incorporate by reference any inconsistent, ambiguous or misleading clauses, exceptions or conditions deceptively affecting the risk purported to be assumed in the affirmative coverage of the contract;

(iii) Does not contain any misleading title, heading or other indication of its coverage;

(iv) Is not printed or otherwise reproduced in such a manner as to render any provision of the form substantially illegible; and

(v) Is otherwise in compliance with this code.

26-23-330. Endorsements.

Any approved policy form or endorsement providing any coverage for which no identifiable premium is assessed shall be incorporated in every policy of title insurance of the type to which the form or endorsement pertains issued by the insurer offering the approved form or endorsements. The insurer shall disclose any such additional coverage to the insured. This section does not operate to eliminate any underwriting standard or conditions relating to the approved policy forms or endorsements.

26-23-331. Notice of issuance of mortgagee policy.

(a) A title insurer or title agent that issues a mortgagee's policy of title insurance on a loan made simultaneous to the purchase of all or part of the residential property securing the loan, if no owner's policy has been ordered, shall inform the borrower in writing that the mortgagee's policy is to be issued, that the mortgagee's policy does not protect the borrower and that the borrower may obtain an owner's title insurance policy for his protection. This notice shall be provided before disbursement of the loan proceeds and before issuance of the mortgagee's policy. The notice shall be on a form the commissioner prescribes.

(b) If the borrower elects not to purchase an owner's title insurance policy, the title insurer or title agent shall obtain from him a statement in writing that the notice has been received and that the borrower waives the right to purchase an owner's title insurance policy. If the buyer refuses to provide the statement and waiver, the title insurer or title agent shall so note in the file. The statement and waiver shall be on a form the commissioner prescribes, and shall be retained by the title insurer or title agent for at least five (5) years after receipt.

26-23-332. Filing by rating bureaus permitted.

(a) A title insurer may satisfy its obligation to make premium rate and form filings as required by this article by becoming a member of, or a subscriber to, a rating organization organized and licensed under this code, which organization makes such filings, and by authorizing the commissioner in writing to accept those filings on its behalf.

(b) Nothing in this article shall be construed as:

(i) Requiring any title insurer to become a member of, or a subscriber to, any rating organization; or

(ii) Prohibiting the filing of deviations from rating organization filings by any member or subscriber.

26-23-333. Regulations.

(a) In addition to any other powers granted under this article, the commissioner may adopt rules or regulations to protect the interests of the public including but not limited to regulations governing:

(i) Sales practices;

(ii) Policy coverage standards;

(iii) Rebates and inducements;

(iv) Controlled business;

(v) Unfair trade practices and fraud;

(vi) Statistical plans for data collection;

(vii) Consumer education;

(viii) Any other consumer matters;

(ix) The business of title insurance; or

(x) Any regulations otherwise implementing or interpreting this article.

26-23-334. Enforcement.

(a) Except as otherwise specifically provided in this article, any person who violates this article in addition to or instead of suspension or revocation of the violator's license, is subject to a civil penalty of five hundred dollars ($500.00) per violation. For purposes of this article each individual transaction which is not in conformance with this article is considered a violation.

(b) This article is enforceable only by the commissioner and shall not create any private cause of action or other private legal recourse.

(c) The commissioner may invoke the aid of the courts in enforcing this article.

26-23-335. Filing of schedule of risk rates; attaching schedule of rates and charges to policy.

Each title insurer shall file with the commissioner a complete schedule of rates for or in connection with title insurance as to property located in this state. The schedule shall set forth the entire premium to be charged to the public for each type of policy included within the schedule and shall include without separate statement the portion of the charge for risk assumption

and the portion which is based on work performed in the search and examination of the title. There shall be no separate filing by an agent of the title insurer.

26-23-336. Mortgagee policies.

If a title insurance policy is issued insuring the title to real estate only as to a mortgagee, the insurer shall conspicuously show on the face of the policy and on any evidence thereof delivered to the mortgagor that coverage is limited to the interest of the mortgagee only.

ARTICLE 4 - GROUP OR MASTER POLICY PROPERTY AND CASUALTY INSURANCE ACT

26-23-401. Qualifications for group or master personal and commercial lines property and casualty insurance policies.

(a) Personal and commercial lines property and casualty insurance may be offered to a resident of this state under a group or master policy issued or delivered pursuant to this section.

(b) Group or master property and casualty personal lines policies shall be subject to the following requirements:

(i) The group or master personal lines property and casualty policy shall not be issued or delivered in this state unless the commissioner finds that:

(A) The issuance of the group or master policy is not contrary to the best interest of the public;

(B) The issuance of the group or master policy would result in economies of acquisition or administration; and

(C) The benefits are reasonable in relation to the premiums charged.

(ii) A group or master personal lines property and casualty insurance coverage shall not be offered in this state by an insurer under a policy issued or delivered in another state unless this state has made a determination that the requirements of subparagraph (b)(i)(C) have been met;

(iii) The premium for the group or master personal lines property and casualty policy shall be paid either from the

policyholder's funds or from funds contributed by the covered persons, or from both.

26-23-402. Group or master policy.

(a) A group or master policy for personal or commercial lines property and casualty insurance coverage shall be issued to the policyholder. Eligible members or covered persons insured under a group or master policy shall be provided evidence of coverage setting forth a statement as to the insurance protection to which they are entitled.

(b) A group or master policy for personal or commercial lines property and casualty insurance coverage shall not be issued or delivered in this state unless the policy form, together with all forms for riders, certificates and endorsements to the policy form, meet the applicable filing requirements in this state. Subsequent amendments to the policy form or forms for riders, certificates and endorsements to the policy form shall not be issued or delivered until they meet the applicable filing requirements in this state.

(c) The group or master personal or commercial lines property and casualty policy shall set forth the coverages, exclusions and conditions of the insurance provided therein, together with the terms and conditions of the agreement between the policyholder and the insurer. The policy shall make express provisions for the following:

(i) Methods of premium collection;

(ii) Enrollment period, effective date provisions and eligibility standards for members or covered persons;

(iii) Termination or modification of the policy; and

(iv) Conversion privileges of the members or covered persons, if any.

(d) If the group or master personal or commercial lines property or casualty master policy provides for remittance of premium by the policyholder, failure of the policyholder to remit premiums when due shall not be regarded as nonpayment of premium by the member or covered person who has made his contribution on a timely basis.

26-23-403. Policy coverage.

(a) Coverage under a group or master personal or commercial lines property and casualty insurance policy may be terminated as to a member or covered person only for:

(i) Failure of the member or covered person to make required premium contributions;

(ii) Termination of the master policy in its entirety or as to the class to which the member or covered person belongs;

(iii) Discontinuance of the member's or covered person's membership in a class eligible for coverage;

(iv) Termination of membership or covered person's services; or

(v) Material misrepresentation of a fact in obtaining coverage which if known to the master policyholder would have caused the master policyholder not to offer coverage to the member or covered person;

(vi) Fraud or material misrepresentation in the presentation of a claim;

(vii) Exhausting the aggregate limit of liability, if any, under the terms of the policy.

(b) Termination of coverage under subsection (a) of this section shall be effective as follows:

(i) Upon written notice made as described in W.S. 26-35-101, or electronic notice if made in connection with portable electronic device insurance, sent not less than ten (10) days prior to the proposed effective date of cancellation if cancellation is for the reason stated in paragraph (a)(i) of this section;

(ii) Immediately if cancellation is for the reasons stated in paragraph (a)(iii), (iv), (v) or (vi) of this section;

(iii) Immediately if cancellation is for the reason stated in paragraph (a)(vii) of this section. However, the insurer shall send notice of cancellation to the covered person within thirty (30) calendar days after exhaustion of the limit and if notice is not timely sent, coverage shall continue

notwithstanding the aggregate limit of liability until the insurer sends notice of termination to the covered person; or

(iv) Upon written notice made as described in W.S. 26-35-101, or electronic notice if made in connection with portable electronic device insurance, sent not less than thirty (30) days prior to the proposed effective date of cancellation if cancellation is for the reason stated in paragraph (a)(ii) of this section.

(c) Coverage under a continuous group or master personal or commercial line property and casualty insurance policy may be modified in accordance with the following:

(i) The insurer shall provide the group or master policyholder and covered persons with at least thirty (30) days prior written notice of the change in coverage; and

(ii) The insurer shall provide the group or master policyholder with a revised policy or endorsement and each covered person with a revised certificate, endorsement, updated brochure or other evidence indicating a change in the terms and conditions has occurred and a summary of material changes.

(d) For purposes of this section:

(i) "Portable electronic device insurance" means as defined in W.S. 26-9-202(a)(xi);

(ii) For portable electronic device insurance electronic notice under the Uniform Electronic Transaction Act, W.S. 40-21-101 through 40-21-119, may be used if the parties have agreed to conduct transactions by electronic means according to W.S. 40-21-105.

26-23-404. Duties and limitations of insurers.

(a) No insurer shall issue or deliver a group or master personal lines property and casualty insurance policy if it is a condition of membership in a group that any member purchase insurance pursuant to the policy, or if any member shall be subject to any penalty by reason of his nonparticipation.

(b) No insurer shall issue or deliver a group personal lines property and casualty insurance policy if:

(i) The purchase of insurance available under the policy is contingent upon the purchase of any other insurance; or

(ii) The purchase or price of any other insurance, product or service is contingent upon the purchase of insurance available under the group personal lines property and casualty insurance policy.

26-23-405. Regulatory jurisdiction.

(a) No master policy or certificate of insurance for group property and casualty insurance coverage shall be issued or delivered in this state unless issued or delivered by an insurer which is duly licensed in this state to write the lines of insurance covered by the master policy.

(b) This article shall not apply to the mass marketing or any other type of marketing of individual property and casualty insurance policies.

(c) This article shall not apply to policies of credit property or credit casualty insurance which insure the debtors of a creditor or creditors with respect to their indebtedness or to policies of lender placed insurance programs.

(d) Nothing in this article shall limit the authority of the insurance commissioner with respect to complaints or disputes involving residents of this state arising out of a master policy that has been issued or delivered in another state.

(e) The insurance commissioner is authorized to promulgate rules and regulations as may be necessary to carry out the provisions of this article.

26-23-406. Effective date.

This article shall take effect July 1, 2013. No master policy or certificate of insurance for group property and casualty insurance coverage shall be issued or delivered in this state after the effective date unless issued or delivered in compliance with this article. A master policy or certificate that is lawfully in effect on July 1, 2013 shall comply with the provisions of this article within twenty-four (24) months of the effective date.

CHAPTER 24 - ORGANIZATION AND CORPORATE PROCEDURES OF LEGAL RESERVE STOCK AND MUTUAL INSURERS

26-24-101. Scope and applicability of chapter.

This chapter applies only to domestic stock insurers and domestic mutual insurers transacting or proposing to transact insurance on the cash premium or legal reserve plan, except that W.S. 26-24-115, 26-24-130 and 26-24-136 also apply to foreign and alien insurers.

26-24-102. Applicability of general corporation statutes; exceptions.

(a) The applicable provisions of the Wyoming Business Corporation Act apply to domestic stock and domestic mutual insurers, except as in conflict with the express provisions of this code and the reasonable implications thereof.

(b) Domestic stock insurers and domestic mutual insurers are exempt from the provisions of W.S. 17-16-1630 and 17-16-1720(e).

26-24-103. Incorporation generally.

(a) This section applies to stock and mutual insurers incorporated in this state.

(b) Five (5) or more individuals may incorporate a stock insurer. Ten (10) or more individuals may incorporate a mutual insurer. At least a majority of the incorporators shall be citizens of the United States. At least a majority of the incorporators shall be residents of this state.

(c) The incorporators shall sign and verify in triplicate articles of incorporation in accordance with the applicable provisions of the Wyoming Business Corporation Act, but subject to the following requirements:

(i) The name of the corporation shall comply with W.S. 26-3-106. If a mutual insurer, "mutual" shall be included in the name. An alternative name may be specified for use in jurisdictions in which conflict of name with that of another insurer or organization might otherwise prevent the insurer from being authorized to transact insurance therein;

(ii) The purposes of the corporation shall be limited to the transaction of one (1) or more kinds of insurance, as defined in this code, and the corporation does not have power to engage in any other or additional business, except that a title insurer may engage in the title abstract business and escrow business;

(iii) If a stock corporation, the capital stock must consist entirely of common stock of one (1) uniform class, par value not less than one dollar ($1.00) per share, each outstanding share of which has equal rights in every respect with every other share, and shares without par value shall not be authorized;

(iv) If a mutual corporation, the articles of incorporation shall state the maximum contingent liability of members for payment of losses and expenses incurred, other than as to nonassessable policies issued as permitted under W.S. 26-24-137, but the liability shall not be less than one (1) nor more than six (6) annual premiums for the member's policy;

(v) The corporation's initial board of directors, as provided for in the articles of incorporation, shall consist of not less than five (5) members;

(vi) The articles of incorporation shall specify which, if any, of the incorporators are not citizens of the United States of America or are not residents of this state.

26-24-104. Articles of incorporation; generally; filing; approval procedure.

(a) The incorporators of a proposed domestic insurer shall deliver the triplicate originals of the articles of incorporation to the commissioner. The commissioner shall deliver one (1) of the originals to the attorney general of this state, and the attorney general shall examine the articles. If the attorney general finds that the articles comply with law, he shall so certify and return the certificate and the original articles of incorporation to the commissioner.

(b) If the attorney general approves the articles of incorporation, the commissioner shall also endorse his approval upon each set of the articles and return them, together with the attorney general's certificate, to the incorporators. The incorporators shall then file one (1) set of the articles of incorporation with the secretary of state, one (1) set with the

commissioner bearing the certification of the secretary of state and shall retain the third set in the corporate records. For the filing of articles of incorporation of a mutual insurer, the secretary of state shall charge and collect a filing fee of twenty-five dollars ($25.00), which shall be credited to the general fund.

(c) If the attorney general finds that the proposed articles do not comply with the law, he shall refuse to approve them and shall return the set thereof to the commissioner, together with a written statement of the respects in which he finds the articles do not comply. The commissioner shall then return all sets of the proposed articles to the proposed incorporators together with the attorney general's written statement.

(d) The secretary of state shall not permit the filing in that office of any articles of incorporation unless they bear the commissioner's approval endorsed thereon as provided in subsection (b) of this section.

(e) The approval of the attorney general or commissioner relates only to the form and contents of the articles of incorporation and does not constitute approval or commitment as to any other aspect or operation of the proposed insurer.

(f) The attorney general and the commissioner shall perform all duties required of them under this section within a reasonable time after the articles of incorporation have been submitted to the commissioner as provided in subsection (a) of this section.

26-24-105. Articles of incorporation; amendment by stock insurers.

(a) A domestic stock insurer may amend its articles of incorporation for any lawful purpose through the same procedures prescribed in the Wyoming Business Corporation Act as for business corporations in general.

(b) Triplicate originals of articles of amendment shall be delivered to the commissioner and are subject to the same examination, certification, approval and filing procedures as provided under W.S. 26-24-104.

26-24-106. Articles of incorporation; amendment by mutual insurers.

(a) A domestic mutual insurer may amend its articles of incorporation for any lawful purpose by affirmative vote of a majority of the members present or represented by proxy at any regular annual meeting of its members, or at any special meeting of members called for the purpose. Written notices of the proposed amendment shall be given members at least thirty (30) days prior to the meeting and may be given in the same manner and at the same time as notice of the meeting is given or in any other appropriate manner.

(b) Upon adoption of the amendment the insurer shall prepare articles of amendment in triplicate under its corporate seal, setting forth the amendment and the date and manner of the adoption thereof. The articles of amendment shall be executed by the insurer's president or vice-president and secretary or assistant secretary, and be acknowledged by them before an officer authorized by law to take acknowledgements of deeds.

(c) The triplicate originals of the articles of amendment shall be delivered to the commissioner and are subject to the same examination, certification, approval and filing procedures as provided for original articles of incorporation under W.S. 26-24-104. For filing articles of amendment of the articles of incorporation of a domestic mutual insurer the secretary of state shall charge and collect a fee of ten dollars ($10.00), which shall be credited to the general fund.

26-24-107. Stock of domestic insurer to be paid for in cash; exceptions.

(a) Except where issued in exchange for other securities for purposes of merger, bulk reinsurance, acquisition of control of another insurer as provided for in this chapter or as stock dividend on a split of stock, no domestic stock insurer shall issue its shares except upon payment in full of the subscription price thereof, not less than par value, in cash.

(b) The value at which any such consideration, other than money, shall be carried in the insurer's financial statement shall be determined as provided in W.S. 26-6-301 through 26-6-304.

26-24-108. Domestic insurers to engage in insurance business exclusively; exception as to title insurers.

No domestic insurer shall engage in any business other than the insurance business and activities reasonably and necessarily incidental thereto, except that a title insurer may also engage in the title abstracting business and act as an escrow agent.

26-24-109. Initial requirements of domestic mutual insurers; authorized transactions.

(a) If newly organized, a domestic mutual insurer may be authorized to transact any one (1) of the kinds of insurance listed in the schedule in subsection (b) of this section.

(b) When applying for a certificate of authority, the insurer shall:

(i) Be otherwise qualified therefor under this code;

(ii) Have received and accepted bona fide applications as to substantial insurable subjects for insurance coverage of a substantial character of the kind of insurance proposed to be transacted;

(iii) Have collected in cash the full premium therefor at a rate not less than that usually charged by other insurers for comparable coverages; and

(iv) Have surplus funds on hand and deposited as of the date the insurance coverages become effective; or

(v) Instead of the applications, premiums and surplus, deposit and thereafter maintain surplus in accordance with that part of the following schedule which applies to the one (1) kind of insurance the insurer proposes to transact:

(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)
Kind of Insur-ance	No. of Apps.	No. Subjects	Minimum Premium	Amt. Ins. ea.	Min. Ins. ea. Subject	Deposit of Min. Surplus	Deposit of Min. Surplus in Lieu
	Min.	Max.					

Ance	Accepted	Covered	Collected	Subject	(v) (vi)	(vi)
Life (i)	200	200	Annual	$ 1,000	$ 2,500	$ 50,000 $ 150,000
Disability	200	200	Quarterly	$ 10	$ 25	$ 50,000 $ 150,000
(ii)				(Weekly		
(Weekly						
Indem.)	Indem.)					
Property	100	250	Annual	$ 1,000	$ 3,000	$ 50,000 $ 200,000
(iii)						
Casualty	150	200	Annual	$ 1,000	$ 10,000	$ 100,000 $ 200,000
(iv)						
excluding						
surety &						
worker’s						
compen-						
sation						
Casualty	200	500	Quarterly	$ 1,000	$ 10,000	$ 150,000 $ 250,000
with						
worker’s						
compen-						
sation						

(c) In addition to surplus deposited and thereafter to be maintained as shown in columns (g) or (h) of the schedule provided in paragraph (b)(v) of this section, the insurer when first authorized shall have on hand surplus funds, which it can thereafter expend in the conduct of its business, in an amount not less than fifty thousand dollars ($50,000.00) or fifty percent (50%) of the deposited surplus required of it under the schedule, whichever is larger.

(d) The following provisions are applicable to the schedule provided in paragraph (b)(v) of this section and provisions as indicated by like roman numerals appearing in that schedule:

(i) No group insurance or term policies for terms of less than ten (10) years shall be included;

(ii) No group, blanket or family plans of insurance shall be included. Instead of weekly indemnity a like premium value in medical, surgical and hospital benefits may be provided. Any accidental death or dismemberment benefit provided shall not exceed two thousand five hundred dollars ($2,500.00);

(iii) Only insurance of the owner's interest in real property may be included;

(iv) Casualty insurance shall include insurance of legal liability for bodily injury and property damage, to which the maximum and minimum insured amounts apply;

(v) The maximums provided for in column (f) of the schedule are net of applicable reinsurance;

(vi) The deposit of surplus in the amount specified in columns (g) and (h) of the schedule shall thereafter be maintained unimpaired. The deposit is subject to chapter 8 of this code.

26-24-110. Bond or deposit required of domestic mutual insurers.

(a) Before soliciting any applications for insurance required under W.S. 26-24-109 as qualifications for the certificate of authority, the incorporators of the proposed insurer shall file with the commissioner a corporate surety bond in the penalty of fifteen thousand dollars ($15,000.00), in favor of the state and for the use and benefit of the state of

the applicant members and creditors of the corporation. The bond shall be conditioned for:

(i) The prompt return to applicant members of all premiums collected in advance;

(ii) Payment of all indebtedness of the corporation; and

(iii) Payment of costs incurred by the state in case of any legal proceedings for liquidation or dissolution of the corporation, if the corporation fails to complete its organization and secure a certificate of authority within one (1) year from the date of its certificate of incorporation.

(b) Instead of the bond specified in subsection (a) of this section, the incorporators may deposit with the commissioner fifteen thousand dollars ($15,000.00) in cash or United States government bonds, negotiable and payable to the bearer, with a market value at all times of not less than fifteen thousand dollars ($15,000.00), to be held in trust upon the same conditions as required for the bond.

(c) Any bond filed or deposit or remaining portion thereof held under this section shall be released and discharged upon settlement and termination of all liabilities against it.

26-24-111. Applications for domestic mutual insurance; solicitation by licensed agents.

(a) Upon receipt of the commissioner's approval of the bond or deposit as provided in W.S. 26-24-110, the directors and officers of the proposed domestic mutual insurer may commence solicitation of the requisite applications for insurance policies and may receive deposits of premiums thereon.

(b) The applications shall be in writing signed by the applicant, covering subjects of insurance resident, located or to be performed in this state.

(c) All applications shall provide that:

(i) Issuance of the policy is contingent upon the insurer qualifying for and receiving a certificate of authority;

(ii) No insurance is in effect until the certificate of authority is issued; and

(iii) The prepaid premium or deposit, and membership or policy fee, if any, shall be refunded in full to the applicant if organization is not completed and the certificate of authority is not issued and received by the insurer before a specified date which shall be not later than one (1) year after the date of the certificate of incorporation.

(d) All qualifying premiums collected shall be in cash.

(e) Solicitation for qualifying applicants for insurance shall be by licensed agents of the corporation, and the commissioner, upon the corporation's application therefor, shall issue temporary agent's licenses expiring on the date specified pursuant to paragraph (c)(iii) of this section to individuals qualified as for a resident agent's license except as to the taking or passing of an examination. The commissioner may suspend or revoke any license for any of the causes and pursuant to the same procedures as are applicable to suspension or revocation of licenses of agents in general under chapter 9 of this code.

26-24-112. Deposit in trust of premiums collected by mutual insurer; release upon issuance of certificate of authority.

(a) All sums collected by a domestic mutual corporation as premiums or fees on qualifying applications for insurance therein shall be deposited in trust in a bank or trust company in this state under a written trust agreement consistent with this section and with W.S. 26-24-111(c)(iii) and 26-24-113. The corporation shall file an executed copy of the trust agreement with the commissioner.

(b) Upon issuance to the corporation of a certificate of authority as an insurer for the kind of insurance for which the applications were solicited, all funds held in trust become the insurer's funds, and the insurer shall thereafter in due course issue and deliver its policies for which premiums were paid and accepted. The insurance provided by the policies is effective as of the date of the certificate of authority or thereafter as the policies provide.

26-24-113. Failure of domestic mutual insurer to qualify.

If the proposed domestic insurer fails to complete its organization and to secure its certificate of authority within

one (1) year from the date of its certificate of incorporation, its corporate powers cease, and the commissioner shall return or cause to be returned to the persons entitled thereto all advance deposits or payments of premiums held in trust under W.S. 26-24-112.

26-24-114. Additional kinds of insurance mutuals.

After being authorized to transact one (1) kind of insurance, a mutual insurer may be authorized to transact any additional kinds of insurance as are permitted under W.S. 26-3-107, while otherwise in compliance with this code and while maintaining unimpaired surplus funds in an amount not less than the amount of paid-in capital stock and surplus required to be maintained by a domestic stock insurer transacting the same kinds of insurance.

26-24-115. Membership in mutuals.

(a) Each policyholder of a domestic mutual insurer, other than a reinsurance contract, is a member of the insurer with all rights and obligations of the membership, and the policy shall so specify.

(b) Any person, government or governmental agency, state or political subdivision thereof, public or private corporation, board, association, firm, estate, trustee or fiduciary may be a member of a domestic, foreign or alien mutual insurer. Any officer, stockholder, trustee or legal representative of any such corporation, board, association or estate may be recognized as acting for or on its behalf for the purpose of the membership, and is not personally liable upon any contract of insurance for acting in that representative capacity.

(c) Any domestic corporation may participate as a member of a mutual insurer as an incidental purpose for which the corporation is organized, and as such is granted the rights and powers expressly conferred.

26-24-116. Bylaws of mutuals.

(a) A domestic mutual insurer shall have bylaws for the government of its affairs. The insurer's initial board of directors shall adopt original bylaws, subject to the approval of the insurer's members at the next meeting of members.

(b) The bylaws shall contain provisions, consistent with this code, relating to:

(i) The voting rights of members;

(ii) Election of directors, and the number, qualifications, terms of office and powers of directors;

(iii) Annual and special meetings of members;

(iv) The number, designation, election, terms and powers and duties of the corporate officers;

(v) Deposit, custody, disbursement and accounting for corporate funds;

(vi) Fidelity bonds covering any officers and employees of the insurer handling its funds, to be issued by a corporate surety and to be in an amount as may be reasonable; and

(vii) Any other matters as may be customary, necessary or convenient for the management or regulation of corporate affairs.

(c) The insurer shall promptly file with the commissioner a copy, certified by the insurer's secretary, of its bylaws and of every modification thereof or addition thereto. The commissioner, after a hearing held thereon, shall disapprove any bylaw provision he deems unlawful, unreasonable, inadequate, unfair or detrimental to the proper interests or protection of the insurer's members or any class thereof. The insurer, after receiving written notice of disapproval and during the existence of that disapproval, shall not carry out any bylaw provision disapproved.

26-24-117. Meetings of members of domestic mutual insurers; where held; annual meeting.

(a) Meetings of members of a domestic mutual insurer shall be held in the city or town of its registered office in this state, except as may otherwise be provided in the insurer's bylaws with the commissioner's approval.

(b) Each domestic mutual insurer, during each calendar year shall:

(i) Hold the annual meeting of its members to fill vacancies existing or occurring in the board of directors;

(ii) Receive and consider reports of the insurer's officers as to its affairs; and

(iii) Transact any other business as may properly be brought before it.

(c) Written notice of the time and place of the annual meeting of members shall be given members not less than thirty (30) days prior to the meeting. Notice may be given by imprinting the notice plainly on the policies issued by the insurer or in any other appropriate manner. Any change of the date or place of the annual meeting shall be made only by an annual meeting of members. Notice of any change, among other appropriate methods, may be given:

(i) By imprinting the new date or place on all policies which will be in effect as of the date of the changed meeting; or

(ii) Unless the commissioner otherwise orders, through policies issued after the date of the annual meeting at which the change was made and in premium notices and renewal certificates issued during the twenty-four (24) months immediately following the meeting.

(d) If the required annual meeting of members has not been held during the previous calendar year, the commissioner, upon written request of any officer, director or member of the insurer, shall cause written notice of the meeting to be given to the insurer's members, and the meeting shall be held as soon as reasonably possible thereafter.

26-24-118. Meetings of members of domestic mutual insurers; special meetings.

(a) A special meeting of the members of a mutual insurer may be held for any lawful purpose. The meeting shall be called by the corporate secretary pursuant to request of the insurer's president or of its board of directors, or upon request in writing signed by not less than one-tenth (1/10) of the insurer's members. The meeting shall be held at such time as the secretary may fix, but not less than ten (10) nor more than thirty (30) days after receipt of the request. If the secretary

fails to issue the call, the president, directors or members making the request may do so.

(b) Not less than ten (10) days written notice of the meeting shall be given. Notice addressed to the insurer's members at their post office addresses last of record with the insurer and deposited, postage prepaid, in a letter depository of the United States post office, is deemed to have been given when so mailed. Instead of a mailed notice the insurer may publish the notice in any publication as shall afford a majority of its members a reasonable opportunity to have actual advance notice of the meeting. The notice shall state the purposes of the meeting, and no business shall be transacted at the meeting of which notice was not so given.

26-24-119. Voting rights of members of mutual insurers.

(a) Each member of a mutual insurer is entitled to one (1) vote upon each matter coming to a vote at meetings of members.

(b) A member has the right to vote in person or by his written proxy filed with the corporate secretary not less than five (5) days prior to the meeting. No proxy shall be made irrevocable, nor be valid beyond the earlier of the following dates:

(i) The date of expiration set forth in the proxy; or

(ii) The date of termination of membership; or

(iii) Five (5) years from the date of execution of the proxy.

(c) No member's vote upon any proposal to divest the insurer of its business or assets, or the major part thereof, shall be registered or taken except in person or by proxy newly executed and specific as to the matter to be voted upon.

26-24-120. Information to stockholders of domestic stock insurers; proxy regulations.

(a) This section applies to all domestic stock insurers except:

(i) A domestic stock insurer having less than one hundred (100) stockholders, except that if ninety-five percent (95%) or more of the insurer's stock is owned or controlled by a

parent or affiliated insurer, this section does not apply to that insurer unless its remaining shares are held by five hundred (500) or more stockholders;

(ii) Domestic stock insurers which file with the securities and exchange commission forms of proxies, consents and authorizations pursuant to the Securities Exchange Act of 1934 (15 U.S.C. § 78a et seq.), as amended.

(b) Any domestic stock insurer subject to this section shall seasonably furnish its stockholders in advance of stockholders meetings, information in writing reasonably adequate to inform them of all matters to be presented by the insurer's management for consideration of stockholders at the meeting.

(c) No person shall solicit a proxy, consent or authorization in respect of any stock of a domestic stock insurer subject to this section unless he furnishes the person solicited with written information reasonably adequate as to:

(i) The material matters in regard to which the powers solicited are proposed to be used; and

(ii) The persons on whose behalf the solicitation is made, and the interest of the persons in relation to those matters.

(d) No person shall furnish to another, information which the informer knows or has reason to believe is false or misleading as to any material fact, or which fails to state any material fact reasonably necessary to prevent any other statement made from being misleading.

(e) Except as provided in subsection (f) of this section, the form of all proxies shall:

(i) Conspicuously state on whose behalf the proxy is solicited;

(ii) Provide for dating the proxy;

(iii) Impartially identify each matter or group of related matters intended to be acted upon;

(iv) Provide means for the principal to instruct the vote of his shares as to approval or disapproval of each matter or group, other than election to office; and

(v) Be legibly printed, with context suitably organized.

(f) A proxy may confer discretionary authority:

(i) As to matters in which choice is not specified pursuant to paragraph (e)(iv) of this section, if the form conspicuously states how it is intended to vote the proxy or authorization in each such case; and

(ii) As to other matters which may come before the meeting but unknown for a reasonable time prior to the solicitation by the persons on whose behalf the solicitation is made.

(g) No proxy shall confer authority to vote:

(i) For election of any person to any office for which a bona fide nominee is not named in the proxy statement; or

(ii) In any annual meeting, or adjournment thereof, other than the annual meeting immediately following the date on which the proxy statement and form are furnished stockholders.

(h) The commissioner may promulgate reasonable rules and regulations to carry out the purpose of this section, and in so doing shall consider rules and regulations promulgated for similar purposes by the insurance supervisory officials of other states.

26-24-121. Boards of directors.

(a) The affairs of each domestic insurer shall be managed by a board of directors consisting of not less than five (5) nor more than twenty-one (21) directors.

(b) Directors, other than initial directors named in the insurer's articles of incorporation, shall be elected by the members or stockholders of a domestic insurer at the annual meeting of stockholders or members. Directors may be elected for terms of not more than five (5) years each and until their successors are elected and have qualified. If the directors are

to be elected for terms of more than one (1) year, the insurer's bylaws shall provide for a staggered term system under which the terms of a proportionate part of the members of the board of directors shall expire on the date of each annual meeting of stockholders or members.

(c) A director of a mutual insurer shall be a policyholder thereof.

(d) As to an insurer operating as an authorized insurer only in the state of Wyoming, a majority of the members of the insurer's board of directors shall be citizens of and shall actually reside in this state.

(e) Any executive committee of a board of directors shall consist of not less than three (3) directors, a majority of whom shall reside in this state.

26-24-122. Notice of changes of officers and directors.

An insurer shall promptly give the commissioner written notice of any change of personnel among its directors or corporate officers.

26-24-123. Management in national emergency; purpose of emergency provisions.

The specific purpose of W.S. 26-24-124 through 26-24-126 is to facilitate the continued operation of domestic insurers if a national emergency is caused by an attack on the United States or by a nuclear, atomic or other disaster which makes it impossible or impracticable for an insurer to conduct its business in strict accord with applicable provisions of law, its bylaws or its charter.

26-24-124. Emergency bylaws.

The board of directors of any domestic insurer may at any time adopt emergency bylaws, subject to repeal or change by action of those having power to adopt regular bylaws for the insurer, which shall be operative during a national emergency and which may, notwithstanding any different provisions of the regular bylaws, or of the applicable statutes, or of the insurer's charter, make any provision that may be reasonably necessary for the insurer's operation during the period of the emergency.

26-24-125. Emergency provisions in lieu of bylaws.

(a) If the board of directors of a domestic insurer does not adopt emergency bylaws, the following provisions are effective in case of a national emergency:

(i) Three (3) directors constitute a quorum for the transaction of business at all board meetings;

(ii) Any board vacancy may be filled by a majority of the remaining directors, though less than a quorum, or by a sole remaining director;

(iii) If there are no surviving directors, but at least three (3) vice-presidents of the insurer survive, the three (3) vice-presidents with the longest term of service are the directors and possess all of the powers of the previous board of directors and any other powers granted under this chapter or by subsequently enacted legislation. By majority vote the emergency board of directors may elect other directors. If there are not at least three (3) surviving vice-presidents, the commissioner or designated person exercising the powers of the insurance commissioner of this state shall appoint three (3) persons as directors who possess all of the powers of the previous board of directors and any other powers granted under this chapter or by subsequently enacted legislation, and these persons by majority vote may elect other directors.

26-24-126. Emergency succession of officers; change of home office location.

(a) The board of directors of a domestic insurer, by resolution, may provide that:

(i) In case of a national emergency and in case of the death or incapacity of the president, the secretary or the treasurer of the insurer, that officer, or any of them, shall be succeeded in the office by the person named or described in a succession list adopted by the board of directors which:

(A) May be on the basis of named persons or position titles;

(B) Shall establish the order of priority; and

(C) May prescribe the conditions under which the powers of the office shall be exercised.

(ii) In case of a national emergency the insurer's home office or principal place of business shall be at a location specified in the resolution, except that the resolution may provide for alternate locations and establish an order of preference.

26-24-127. Pecuniary interests of officers or directors prohibited.

(a) Any officer or director, or any member of any committee or an employee of a domestic insurer, who is charged with the duty of investing or handling the insurer's funds shall not:

(i) Deposit or invest those funds except in the insurer's corporate name;

(ii) Borrow the insurer's funds;

(iii) Be pecuniarily interested in any loan, pledge or deposit, security, investment, sale, purchase, exchange, reinsurance or other similar transaction or property of the insurer except as a stockholder or member;

(iv) Take or receive to his own use any fee, brokerage, commission, gift or other consideration for or on account of any transaction made by or on behalf of the insurer.

(b) No insurer shall guarantee any financial obligation of any of its officers or directors.

(c) This section does not prohibit any director or officer, or member of a committee or employee from:

(i) Becoming a policyholder of the insurer and enjoying the usual rights provided for its policyholders;

(ii) Participating as beneficiary in any pension trust, deferred compensation plan, profit sharing plan or stock option plan authorized by the insurer and to which he may be eligible; or

(iii) Receiving a reasonable fee for lawful services actually rendered to the insurer.

(d) The commissioner, by regulation, may define and permit additional exceptions to the prohibition contained in subsection (a) of this section solely to enable payment:

(i) Of reasonable compensation to a director who is not otherwise an insurer's officer or employee; or

(ii) To a corporation or firm in which a director is interested, for necessary services performed or sales or purchases made to or for the insurer in the ordinary course of the insurer's business and in the usual private professional or business capacity of the director, corporation or firm.

26-24-128. Management and exclusive agency contracts.

(a) No domestic insurer shall make any contract in which any person is granted or is to enjoy in fact the management of the insurer to the substantial exclusion of its board of directors, or to have the controlling or preemptive right to produce substantially all insurance business for the insurer, or, if an officer, director or otherwise part of the insurer's management, is to receive any commission, bonus or compensation based upon the volume of the insurer's business or transactions, unless the contract is filed with and approved by the commissioner. The contract is approved unless disapproved by the commissioner within twenty (20) days from the date of filing, subject to any reasonable time extension the commissioner requires by notice given within the twenty (20) days. Any disapproval shall be delivered to the insurer in writing, stating the grounds for the disapproval.

(b) Any contract specified in subsection (a) of this section shall provide that any manager or producer of its business, within ninety (90) days after expiration of each calendar year, shall furnish the insurer's board of directors a written statement of amounts received under or on account of the contract and amounts expended thereunder during the calendar year, including the emoluments received therefrom by the directors, officers and other principal management personnel of the manager or producer, and with any classification of items and further detail as the insurer's board of directors reasonably requires.

(c) The commissioner shall disapprove any contract specified in this section if he finds that it:

(i) Subjects the insured to excessive charges;

(ii) Is to extend for an unreasonable length of time;

(iii) Does not contain fair and adequate standards of performance; or

(iv) Contains other inequitable provisions or provisions which impair the proper interests of stockholders or policyholders of the insurer.

(d) The commissioner, after a hearing held thereon, may withdraw his approval of any contract he approved, if he finds that the basis of his original approval no longer exists, or that the contract, in actual operation, is subject to disapproval on any of the grounds referred to in subsection (c) of this section.

(e) This section does not apply to contracts entered into prior to January 1, 1968, nor to extensions or amendments to those contracts.

26-24-129. Home office records and assets; penalty for removal; out-of-state branch operations.

(a) Any domestic insurer shall:

(i) Have and maintain its principal place of business and home office in this state;

(ii) Keep in the principal place of business accurate and complete accounts and records of its assets, transactions and affairs in accordance with the usual and accepted principles and practices of insurance accounting and record keeping as applicable to the kinds of insurance the insurer transacts;

(iii) Have and maintain its assets in this state, except as to:

(A) Real property and personal property appurtenant thereto lawfully owned by the insurer and located outside this state; and

(B) Any property of the insurer as may be customary, necessary and convenient to enable and facilitate the operation of its branch offices located outside this state as referred to in subsection (d) of this section.

(b) No person shall:

(i) Remove all or a material part of the records or assets of a domestic insurer from this state except:

(A) Pursuant to a plan of merger, consolidation or bulk reinsurance which the commissioner approves under this code; or

(B) For any reasonable purposes and periods of time as the commissioner approves in writing in advance of the removal; or

(ii) Conceal the records or assets or a material part thereof from the commissioner;

(iii) Retain any records or assets or a material part thereof outside this state beyond the period authorized in the commissioner's approval under which the records were removed.

(c) Any person who violates any provision of subsection (b) of this section is guilty of a felony and, upon conviction, shall be punished by a fine of not more than ten thousand dollars ($10,000.00), or by imprisonment in the penitentiary for not more than five (5) years, or both. The commissioner may also institute delinquency proceedings against the insurer pursuant to chapter 28 of this code.

(d) This section does not prohibit an insurer from:

(i) Establishing and maintaining branch offices in other states if necessary or convenient to the transaction of its business and keeping in those branch offices the detailed records and assets customary and necessary for the servicing of its insurance in force and affairs in the territory served by the branch office, as long as the records and assets are made readily available at the branch office for examination by the commissioner at his request;

(ii) Having, depositing or transmitting the insurer's funds and assets in or to jurisdictions outside of this state required by the law of that jurisdiction or as reasonably and customarily required in the regular course of its business.

(e) An insurer may request an exemption, in writing, from holding its invested assets at a financial institution that has a physical location in this state if the insurer provides

sufficient documentation that the financial institutions in this state do not have adequate technology to support the insurer's required financial reporting requirements or the financial institutions' fees are cost prohibitive for the insurer. The commissioner shall issue an order approving or denying the exemption request within thirty (30) days after all supporting documentation for the request has been received. The commissioner may vacate any previous exemption order upon the determination that there are financial institutions with physical locations in this state that provide adequate technology and competitive fee structures or if the insurer is experiencing material financial solvency concerns. The commissioner shall provide any insurer that has had its previous approval to use an out-of-state financial institution revoked at least thirty (30) days to return its invested assets to this state. Before moving any of its invested assets, the insurer shall execute a custodial agreement with the financial institution that has been approved by the commissioner.

26-24-130. Voucher required for disbursements.

(a) No insurer shall make any disbursement of seventy-five dollars ($75.00) or more, unless evidenced by a voucher or other document correctly describing the consideration for the payment and supported by a check or receipt endorsed or signed by or on behalf of the person receiving the money.

(b) If the disbursement is for services and reimbursement, the voucher or other document, or some other provision referred to in the voucher or other document, shall describe the services and itemize the expenditures.

(c) If the disbursement is in connection with any matter pending before any public body or public official, the voucher or other document shall also correctly describe the nature of the matter and of the insurer's interest therein.

(d) If a voucher cannot be obtained, the expenditure shall be supported by an affidavit executed by an officer of the insurer stating the reasons for the inability to obtain a voucher and the particulars of the expenditure as otherwise required by this section.

26-24-131. Borrowing by insurers.

(a) A domestic stock or mutual insurer may borrow money to defray the expenses of its organization, provide it with surplus

funds or for any other purpose of its business, upon a written agreement that the money is required to be repaid only out of the insurer's surplus in excess of that stipulated in the agreement. The agreement may provide for interest not exceeding six percent (6%) per annum, which interest shall or shall not constitute a liability of the insurer as to its funds other than the excess of surplus, as stipulated in the agreement. No commission or promotion expense shall be paid in connection with any such loan, except that if public offering and sale is made of the loan securities, the insurer may pay the reasonable costs thereof the commissioner approves.

(b) Any money borrowed as provided in subsection (a) of this section, together with the interest thereon if stipulated in the agreement, shall not form a part of the insurer's legal liabilities except as to its surplus in excess of the amount stipulated in the agreement, or be the basis of any setoff. Until the money is repaid financial statements filed or published by the insurer shall show as a footnote thereto the amount then unpaid together with any interest thereon accrued but unpaid.

(c) Any loan under this section is subject to the commissioner's approval. The insurer, in advance of the loan, shall file with the commissioner a statement of the purpose of the loan and a copy of the proposed loan agreement. The loan and agreement are deemed approved unless within fifteen (15) days from the date of filing, the insurer is notified of the commissioner's disapproval and the reasons therefor. The commissioner shall disapprove any proposed loan or agreement if he finds the loan is unnecessary or excessive for the purpose intended, or that the terms of the loan agreement are not fair and equitable to the parties and to other similar lenders, if any, to the insurer, or that the information filed by the insurer is inadequate.

(d) Any loan, under this section, or substantial portion thereof, to a mutual insurer shall be repaid by the insurer when no longer reasonably necessary for the purpose originally intended. No repayment of a loan shall be made by a mutual insurer unless the commissioner approves it in advance.

(e) This section does not apply to other kinds of loans obtained by the insurer in ordinary course of business, nor to loans secured by pledge or mortgage of assets.

26-24-132. Participating policies.

(a) If provided for in its articles of incorporation or charter, a stock insurer or mutual insurer may:

(i) Issue any of its policies or contracts with or without participation in profits, savings, unabsorbed portions of premiums or surplus;

(ii) Classify policies issued and risks insured on a participating and nonparticipating basis; and

(iii) Subject to W.S. 26-16-503, determine the right to participate and the extent of participation of any classes of policies. Any such classification or determination shall be reasonable.

(b) A life insurer may issue both participating and nonparticipating policies or contracts only if the right or absence of right to participate is reasonably related to the premium charged.

(c) After the third policy year, no dividend, otherwise earned, is contingent upon the payment of renewal premium on any policy or contract.

26-24-133. Dividends to stockholders.

(a) No domestic stock insurer shall pay any cash dividend to stockholders except out of that part of its available and accumulated surplus funds which is derived from realized net operating profits on its business and realized capital gains.

(b) A cash dividend otherwise lawful may be payable out of the insurer's earned surplus even though its total surplus is then less than the aggregate of its past contributed surplus resulting from issuance of its capital stock at a price in excess of the par value thereof.

(c) A stock dividend may be paid out of any available surplus funds in excess of the aggregate amount of surplus advanced to the insurer under arrangements authorized in W.S. 26-24-131 and then remaining unpaid by the insurer.

(d) Payment of a stock dividend is otherwise subject to W.S. 17-16-623.

26-24-134. Dividends to policyholders of mutual insurer.

(a) The directors of a domestic mutual insurer may apportion and pay or credit to its members dividends only out of that part of its surplus funds which represents net realized savings, net realized earnings and net realized capital gains, all in excess of the surplus the insurer is required by law to maintain.

(b) A dividend otherwise proper may be payable out of the savings, earnings and gains even though the insurer's total surplus is then less than the aggregate of contributed surplus remaining unpaid by the insurer.

(c) A domestic stock insurer may pay dividends to holders of its participating policies out of any available surplus funds.

(d) No dividend shall be paid which is inequitable, or which unfairly discriminates as between classifications of policies or policies within the same classifications.

(e) This section is subject to W.S. 26-16-503(c).

26-24-135. Contingent liability of mutual member generally.

(a) Except as otherwise provided in W.S. 26-24-138 with respect to nonassessable policies, each member of a domestic mutual insurer has a contingent liability, pro rata and not one (1) for another, for the discharge of its obligations. The contingent liability shall be in the maximum amount specified in the insurer's articles of incorporation consistent with W.S. 26-24-103(c)(iv).

(b) Any policy the insurer issues shall contain a statement of the contingent liability.

(c) Termination of any member's policy does not relieve the member of contingent liability for his proportion of the obligations of the insurer which accrue while the policy is in force as provided in W.S. 26-24-136.

(d) Unrealized contingent liability of members does not constitute an asset of the insurer in any determination of its financial condition.

26-24-136. Levy of contingent liability.

(a) If at any time the assets of a domestic mutual insurer are less than its liabilities and the minimum amount of surplus required to be maintained by it under this code for authority to transact the kinds of insurance being transacted, and the deficiency is not secured from other sources, its directors, if approved by the commissioner, may levy an assessment only on its members who held policies providing for contingent liability at any time within the twelve (12) months immediately preceding the date the board of directors authorized the levy. Those members are liable to the insurer for the amount assessed.

(b) The levy of assessment shall be for the amount, subject to the commissioner's approval, required to cure the deficiency and to provide a reasonable amount of working funds above the minimum amount of surplus. The working funds shall not exceed five percent (5%) of the sum of the insurer's liabilities and the minimum required surplus as of the date of the levy.

(c) The assessment shall be computed upon a reasonable basis the commissioner approves in writing in advance of the levy.

(d) No member has an offset against any assessment for which he is liable, because of any claim for unearned premium or loss payable.

(e) As to life insurance, any part of an assessment upon a member which remains unpaid following notice of assessment, demand for payment and lapse of a reasonable waiting period as specified in the notice, if approved by the commissioner as being in the best interests of the insurer and its members, may be secured by placing a lien upon the cash surrender values and accumulated dividends held by the insurer to the credit of the member.

26-24-137. Enforcement of contingent liability.

(a) The insurer shall notify each member of the amount of the assessment to be paid by written notice mailed to the member's address last of record with the insurer. Failure of the member to receive the notice within the time specified therein for the payment of the assessment or at all, is no defense in any action to collect the assessment.

(b) If a member fails to pay the assessment within the period specified in the notice, which period shall not be less

than twenty (20) days from the date of mailing, the insurer may institute suit to collect the assessment.

26-24-138. Nonassessable policies.

(a) A domestic mutual insurer while maintaining unimpaired surplus funds not less in amount than the minimum paid-in capital stock and surplus required to be maintained by a domestic stock insurer, formed under this code, for authority to transact the same kinds of insurance, upon receipt of the commissioner's order so authorizing, may extinguish the contingent liability to assessment of its members as to all its policies in force and may omit provisions imposing contingent liability in all policies currently issued.

(b) The commissioner shall not authorize a domestic insurer to extinguish the contingent liability of any of its members or in any of its policies to be issued, unless it qualifies to and does extinguish the liability of all its members and in all its policies for all kinds of insurance it transacted.

(c) A foreign or alien mutual insurer may issue nonassessable policies to its members in this state pursuant to its charter and the laws of its domicile.

26-24-139. Revocation of authority to issue policies without contingent liability.

(a) The commissioner shall revoke the authority of a domestic mutual insurer to issue policies without contingent liability if:

(i) At any time the insurer's assets are less than the sum of its liabilities and the surplus required for authority; or

(ii) The insurer, by resolution of its board of directors approved by a majority of its members, requests that the authority be revoked.

(b) Without authority the insurer shall not:

(i) Issue any policy without providing therein for the policyholder's contingent liability; or

(ii) Renew any policy which is then in force without endorsing that policy to provide for contingent liability.

26-24-140. Issuance of policies in other states.

A domestic insurer authorized to transact insurance in another jurisdiction may frame and issue policies for delivery in that jurisdiction pursuant to application for insurance solicited and obtained therein, in accordance with the laws thereof, subject only to those restrictions, if any, contained in the insurer's charter or bylaws.

26-24-141. Impairment of capital or assets; generally.

(a) If a domestic stock insurer's paid-in capital stock, as represented by the aggregate par value of its outstanding capital stock, or the amount of its surplus, or if the amount of a domestic mutual insurer's surplus, is less than the minimum amounts the insurer is required to maintain under this code for authority to transact the kinds of insurance being transacted, the commissioner shall at once determine the amount of deficiency and notify the insurer to cure the deficiency and file proof thereof with him within the period specified in the notice. The period shall be not less than thirty (30) nor more than ninety (90) days from the date of the notice. The notice may be served by delivery to the insurer or by mailing to the insurer addressed to its principal place of business in this state.

(b) The deficiency shall be made good:

(i) In cash or in assets eligible for investment of the insurer's funds;

(ii) By amendment of the insurer's certificate of authority to cover only the kinds of insurance thereafter for which the insurer has sufficient paid-in capital stock and surplus, if a stock insurer, or surplus, if a mutual insurer, under this code; or

(iii) If a stock insurer, by reduction of the insurer's stated capital or any other lawful means, so that the insurer's resulting paid-in capital stock and surplus are not below the minimums required for the kinds of insurance it transacts.

(c) After any reduction of stated capital, if the reduction results in a decrease in the number of par values of its outstanding capital stock, the insurer's stockholders shall surrender to the insurer their affected stock certificates in exchange for new certificates to be issued for such number or par value of shares, or both, as the stockholders are then entitled to receive.

(d) If the deficiency is not cured and proof thereof filed with the commissioner within the period required by the notice as specified in subsection (a) of this section, the commissioner shall:

(i) Immediately and without further notice or hearing suspend or revoke the insurer's certificate of authority; and

(ii) Take any further action authorized under chapter 28 of this code.

26-24-142. Impairment of capital or assets; liability of directors for deficiencies.

If the insurer fails to cure the deficiency within the period allowed therefor under W.S. 26-24-141, the insurer's directors are personally liable for payment of any losses or insurance benefits on new insurance risks the insurer assumes after expiration of the period, unless the insurer's certificate of authority is thereafter reinstated.

26-24-143. Impairment of capital or assets; assessment of stockholders or members.

(a) If an insurer is a stock insurer and receives the notice specified in W.S. 26-24-141(a) and to the extent that stockholders are subject to assessment under the insurer's articles of incorporation, by resolution of its board of directors, the insurer may assess its stockholders for amounts necessary to cure the deficiency and provide the insurer with a reasonable amount of additional surplus. If any stockholder fails to pay a lawful assessment after notice given to him in person, or by mail addressed to him at his address last of record with the insurer, or in any other manner the commissioner approves, the insurer may cancel and require the return of the certificates of stock then held by the stockholder. The insurer shall issue new certificates for that number of shares as the stockholder is then entitled to upon the basis of the stockholder's proportionate interest in the amount of the

insurer's capital stock as the commissioner determines to be remaining unimpaired at the time of the determination of the amount of impairment under W.S. 26-24-141, after deducting from the proportionate interest the amount of the unpaid assessment. The insurer may pay for or issue fractional shares under this subsection.

(b) If an insurer is a mutual insurer and receives the notice specified in W.S. 26-24-141(a), it may levy an assessment upon members as provided in W.S. 26-24-136.

(c) Neither this section nor W.S. 26-24-141 prohibits the insurer from curing any deficiency through any lawful means.

26-24-144. Impairment of capital or assets; transfer of shares during impairment.

Transfer of shares of stock of a domestic stock insurer made at a time when the insurer's capital or surplus is impaired, as referred to in W.S. 26-24-141(a), whether before, during or after the period allowed by the commissioner for curing the impairment, does not release the party making the transfer from liability as to impairment accruing prior to the transfer and while the party was a stockholder.

26-24-145. Mutualization of stock insurer.

(a) A stock insurer may become a mutual insurer under any reasonable plan and procedure the commissioner approves after a hearing thereon.

(b) The commissioner shall not approve any plan, procedure or mutualization unless:

(i) It is equitable to stockholders and policyholders;

(ii) It is subject to approval by the holders of not less than three-fourths (3/4) of the insurer's outstanding capital stock having voting rights, and by not less than two-thirds (2/3) of the insurer's policyholders who vote on the plan in person, by proxy or by mail pursuant to a reasonable notice and procedure the commissioner approves;

(iii) If a life insurer, the right to vote thereon is limited to holders of policies, other than term or group

policies, whose policies have been in force for more than one (1) year;

(iv) Mutualization will result in retirement of shares of the insurer's capital stock at a price not exceeding the fair market value thereof as determined by competent disinterested appraisers;

(v) The plan provides for the purchase of the shares of any dissenting stockholder in the same manner and subject to the same applicable conditions as provided by the Wyoming Business Corporation Act as to rights of dissenting stockholders with respect to merger or consolidation of business corporations;

(vi) The plan provides for definite conditions to be fulfilled by a designated early date upon which the mutualization is effective; and

(vii) The mutualization leaves the insurer with surplus funds reasonably adequate for its policyholders' security and to enable it to continue successfully in business in the states in which it is then authorized to transact insurance and for the kinds of insurance included in its certificates of authority in those states.

(c) This section does not apply to a mutualization under order of the court pursuant to an insurer's rehabilitation or reorganization under chapter 28 of this code.

26-24-146. Converting mutual insurer to stock insurer.

(a) A mutual insurer may become a stock insurer under any plan and procedure the commissioner approves after a hearing thereon.

(b) The commissioner shall not approve any plan or procedure unless:

(i) It is equitable to the insurer's members;

(ii) It is subject to approval by vote of not less than three-fourths (3/4) of the insurer's current members voting thereon in person, by proxy or by mail at a meeting of members called for the purpose pursuant to a reasonable notice and procedure the commissioner approves, except if the insurer is a life insurer, right to vote may be limited to members who hold

policies other than term or group policies, and whose policies have been in force for not less than one (1) year;

(iii) The equity of each policyholder in the insurer is determinable under a fair formula which the commissioner approves, and the equity is based upon not less than the insurer's entire surplus, after deducting contributed or borrowed surplus funds, plus a reasonable present equity in its reserves and all nonadmitted assets;

(iv) The policyholders entitled to participate in the purchase of stock or distribution of assets shall include all current policyholders and all existing persons who had been policyholders of the insurer within three (3) years prior to the date the plan was submitted to the commissioner;

(v) The plan gives to each policyholder of the insurer as specified in paragraph (iv) of this subsection, a preemptive right to acquire his proportionate part of all of the insurer's proposed capital stock, within a designated reasonable period, and to apply upon the purchase thereof the amount of his equity in the insurer as determined under paragraph (iii) of this subsection;

(vi) Shares are so offered to policyholders at a price not greater than to be thereafter offered to others;

(vii) The plan provides for payment to each policyholder not electing to apply his equity in the insurer for or upon the purchase price of stock to which preemptively entitled, of cash in the amount of not less than fifty percent (50%) of the amount of his equity not used for the purchase of stock, and which cash payment together with stock purchased, if any, constitutes full payment and discharge of the policyholder's equity as an owner of the mutual insurer; and

(viii) The plan, when completed, provides for the converted insurer paid-in capital stock and surplus in an amount not less than the minimum paid-in capital stock and maintained surplus required of a domestic stock insurer transacting like kinds of insurance, together with expendable surplus funds in an amount not less than one-half (1/2) of the required capital stock and maintained surplus.

26-24-147. Merger or consolidation of stock insurers.

(a) A domestic stock insurer may merge or consolidate with one (1) or more domestic or foreign stock insurers by complying with the applicable provisions of the statutes of this state governing the merger or consolidation of stock corporations formed for profit, but subject to subsections (b) and (c) of this section.

(b) No merger or consolidation shall be carried out unless the plan and agreement therefor have been filed with the commissioner and he approves the plan and agreement in writing after a hearing thereon including appropriate notice to the stockholders of each insurer involved. The commissioner shall approve the merger or consolidation within a reasonable time after the filing unless he finds the plan or agreement:

(i) Is contrary to law;

(ii) Is inequitable to the stockholders of any insurer involved;

(iii) Would substantially reduce the security of and service to be rendered to the domestic insurer's policyholders in this state or elsewhere;

(iv) Would materially tend to lessen competition in the insurance business in this state or elsewhere as to the kinds of insurance involved or would materially tend to create any monopoly as to that business; or

(v) Is subject to other material and reasonable objections.

(c) No director, officer, agent or employee of any insurer party to the merger or consolidation, or member of the family of a director, officer, agent or employee, shall receive any fee, commission, compensation or other valuable consideration for in any manner aiding, promoting or assisting therein except as set forth in the plan or agreement.

(d) If the commissioner does not approve the plan or agreement he shall notify the insurer in writing specifying his reasons for disapproval.

26-24-148. Acquisitions and exchanges in shares of another stock insurer.

(a) A domestic stock insurer shall not acquire a controlling interest in the shares of another stock insurer by an exchange of securities or partly in exchange for securities and partly for cash or property, unless the insurer first submits the plan for the acquisition and exchange to the commissioner and the commissioner approves the plan.

(b) The commissioner shall not approve a plan of acquisition and exchange unless:

(i) He finds the plan is fair and equitable to all parties concerned;

(ii) He holds a hearing to which all persons to whom it is proposed to issue securities in the exchange have the right to appear;

(iii) Notice is provided and the hearing conducted as provided in chapter 2 of this code.

26-24-149. Mutual and stock insurer merger prohibited; merger or consolidation of mutual insurers.

(a) A domestic mutual insurer shall not merge or consolidate with a stock insurer.

(b) A domestic mutual insurer may merge or consolidate with another mutual insurer under the applicable procedures prescribed by the Wyoming Business Corporation Act, except as otherwise provided in this section.

(c) If the insurer is then unimpaired, the plan and agreement for merger or consolidation shall be submitted to and approved by at least two-thirds (2/3) of the members of each mutual insurer voting thereon at meetings called for the purpose pursuant to any reasonable notice and procedure the commissioner approves. If a life insurer, right to vote may be limited to members whose policies are other than term and group policies and have been in effect for more than one (1) year.

(d) No merger or consolidation shall be carried out unless the plan and agreement therefor are filed with the commissioner and he approves the plan and agreement in writing. If the insurer is not then impaired the commissioner shall not act upon the plan and agreement until after a hearing thereon. The commissioner shall approve the plan and agreement within a

reasonable time after filing unless he finds the plan or agreement:

(i) Inequitable to the policyholders of any domestic insurer involved;

(ii) Would substantially reduce the security of and service to be rendered to policyholders of the domestic insurer in this state and elsewhere;

(iii) Would materially tend to lessen competition in the insurance business in this state or elsewhere as to the kinds of insurance involved, or would materially tend to create any monopoly as to that business; or

(iv) Is subject to other material and reasonable objections.

(e) If the commissioner does not approve the plan or agreement he shall notify the insurers in writing specifying his reasons therefor.

(f) No director, officer, agent or employee of any insurer party to the merger or consolidation, nor any other person, shall receive any fee, commission or other valuable consideration for in any manner aiding, promoting or assisting therein except as set forth in the plan and agreement.

26-24-150. Bulk reinsurance.

(a) A domestic insurer may reinsure all or substantially all of its business in force, or all or substantially all of a major class thereof, with another insurer, stock or mutual, by an agreement of bulk reinsurance after compliance with this section. No agreement is effective unless it is filed with the commissioner and he approves it in writing.

(b) The commissioner shall approve an agreement within a reasonable time after filing if he finds that:

(i) The plan and agreement are fair and equitable to each insurer and to the policyholders involved;

(ii) The reinsurance, if carried out, would not substantially reduce the protection or service to the policyholders of any domestic insurer involved;

(iii) The agreement embodies adequate provisions by which the reinsuring insurer is liable to the original insureds for any loss or damage occurring under the policies reinsured in accordance with the original terms of the policies, and the reinsuring insurer shall furnish each insured with a certificate evidencing assumption of liability;

(iv) The assuming reinsurer is authorized to transact insurance in this state, or is qualified for authorization and will appoint the commissioner and his successors as its irrevocable attorney for service of process, as long as any policy reinsured or claim thereunder remains in force or outstanding;

(v) The reinsurance would not materially tend to lessen competition in the insurance business in this state or elsewhere as to the kinds of insurance involved, and would not materially tend to create any monopoly as to that business; and

(vi) The proposed bulk reinsurance is free of other reasonable objections.

(c) If the commissioner does not approve the agreement he shall immediately notify each insurer involved, in writing, specifying his reasons for disapproval.

(d) If for reinsurance of any of the business in force of a mutual insurer at a time when the insurer's surplus is not impaired, the plan and agreement for reinsurance shall be approved by vote of not less than two-thirds (2/3) of the mutual insurer's members voting thereon at a meeting of members called for that purpose, pursuant to any reasonable notice and procedure provided for in the agreement. If a life insurer, the right to vote may be limited to members whose policies are other than term or group policies and have been in effect for more than one (1) year.

(e) No director, officer, agent or employee of any insurer party to the reinsurance, nor any other person, shall receive any compensation for arranging the bulk reinsurance other than as provided in the agreement submitted to and approved by the commissioner.

26-24-151. Mutual members' share of assets upon liquidation.

(a) If a domestic mutual insurer is liquidated, its assets remaining after discharge of its indebtedness, policy obligations, repayment of contributed or borrowed surplus, if any, and expenses of administration, shall be distributed to currently existing persons who were members of the insurer for at least one (1) year and who were its members at any time within thirty-six (36) months preceding the date the liquidation was authorized or ordered, or the date of last termination of the insurer's certificate of authority, whichever is earlier. If the commissioner has reason to believe that the insurer's management caused or encouraged a reduction in the number of the insurer's members in anticipation of liquidation and for the purpose of reducing thereby the number of persons entitled to share in distribution of the insurer's assets, he may enlarge the thirty-six (36) month qualification period by any additional period he deems reasonable.

(b) The insurer shall make a reasonable classification of its policies held by the members specified in subsection (a) of this section and a formula based upon that classification for determining the equitable distributive share of each such member. The classification and formula are subject to the commissioner's approval.

CHAPTER 25 - INSIDER TRADING IN DOMESTIC INSURER SECURITIES

26-25-101. Scope and applicability of chapter.

This chapter applies only to securities issued by domestic stock insurers.

26-25-102. "Equity security" defined.

(a) As used in this chapter "equity security" means:

(i) Any stock or similar security;

(ii) Any security convertible, with or without consideration, into stock or a similar security, or carrying any warrant or right to subscribe to or purchase such a security;

(iii) Any warrant or right to subscribe to or purchase stock or a similar security; or

(iv) Any other security which the commissioner deems to be of similar nature and considers necessary or appropriate to treat as an equity security, by rules and regulations he

prescribes, in the public interest or for the protection of investors.

26-25-103. Statement of ownership of equity securities; when filing required.

(a) Any person who is the beneficial owner of more than ten percent (10%) of any class of any equity security of a domestic stock insurer, or who is a director or an officer of that insurer, shall:

(i) File with the commissioner within ten (10) days after he becomes the beneficial owner, director or officer, a statement, in a form the commissioner prescribes, of the amount of all the insurer's equity securities of which he is the beneficial owner; and

(ii) Within ten (10) days after the close of each calendar month following the initial filing, if there is a change in ownership during that month, file with the commissioner a statement, in a form the commissioner prescribes, indicating his ownership at the close of the calendar month and any changes in his ownership that have occurred during that calendar month.

26-25-104. Recovery of profits from certain sales and purchases of equity securities.

(a) For the purpose of preventing the unfair use of information obtained by the beneficial owner, director or officer because of his relationship to the insurer, any profit the beneficial owner, director or officer realizes from any purchase and sale, or any sale and purchase, of any equity security of the insurer within any period of less than six (6) months, unless the security is acquired in good faith in connection with a debt previously contracted, inures to and is recoverable by the insurer, even if it is the intention 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 (6) months from the date of the purchase or sale, as the case may be.

(b) Suit to recover the profit may be instituted in any court of competent jurisdiction by the insurer, or by the owner of any of the insurer's security in the name and in behalf of the insurer, if the insurer fails to bring suit within sixty

(60) days from the date of request to do so or fails diligently to prosecute the suit thereafter. No suit to recover shall be brought more than two (2) years from the date the profit is realized.

(c) This section does not apply to any transaction:

(i) If the beneficial owner is not the beneficial owner both at the time of the purchase and sale, or the sale and purchase, of the security involved; or

(ii) Which the commissioner by rule and regulation exempts as not included within the purpose of this section.

26-25-105. Unlawful sales of equity securities.

(a) No beneficial owner, director or officer shall sell any equity security of the insurer if the person selling the security or his principal:

(i) Does not own the security sold;

(ii) If owning the security, does not deliver it against the sale within twenty (20) days from the date of sale; or

(iii) Does not within five (5) days from the date of sale deposit it in the mails or other usual channels of transportation.

(b) No person is guilty of violating this section if he proves that notwithstanding the exercise of good faith he was unable to make the delivery or deposit within the time specified in subsection (a) of this section, or that making the delivery or deposit would have caused undue inconvenience or expense.

26-25-106. Excepted securities.

(a) W.S. 26-25-104 does not apply to any purchase and sale, or sale and purchase, and W.S. 26-25-105 does not apply to any sale, of an equity security of a domestic stock insurer, not then or previously held by the insurer in an investment account, by a dealer in the ordinary course of his business and incident to the dealer's establishment or maintenance of a primary or secondary market, otherwise than on an exchange as defined in the Securities Exchange Act of 1934, 15 U.S.C. § 78a et seq., for the security.

(b) The commissioner, by rules and regulations he deems necessary or appropriate in the public interest, may prescribe terms and conditions for 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.

26-25-107. Arbitrage transactions excluded; exception.

W.S. 26-25-103 through 26-25-105 do not apply to foreign or domestic arbitrage transactions unless made in contravention of any rules and regulations the commissioner adopts to carry out the purposes of this chapter.

26-25-108. Exclusion of certain registered or closely held securities.

(a) W.S. 26-25-103 through 26-25-105 do not apply to equity securities of a domestic stock insurer if:

(i) The securities are registered or are required to be registered, pursuant to section 12 of the Securities Exchange Act of 1934, 15 U.S.C. § 78l, as amended; or

(ii) The domestic stock insurer does not have any class of its equity securities held of record by one hundred (100) or more persons on the last business day of the year immediately preceding the year in which the insurer's equity securities would be subject to the provisions of W.S. 26-25-103 through 26-25-105, except for the provisions of this paragraph.

26-25-109. Commissioner's rules and regulations.

The commissioner may make any rules and regulations necessary for the execution of the functions vested in him by this chapter, and for that purpose may classify domestic stock insurers, securities and other persons or matters within his jurisdiction. No provision of W.S. 26-25-103 through 26-25-105 imposing any liability applies to any act performed or omitted in good faith in conformity with any rule or regulation of the commissioner, notwithstanding that the rule or regulation, after the act or omission, is amended or rescinded or determined by judicial or other authority to be invalid for any reason.

26-26-101. Repealed by Laws 2018, ch. 21, § 2.

26-26-102. Repealed by Laws 2018, ch. 21, § 2.

26-26-103. Repealed by Laws 2018, ch. 21, § 2.

26-26-104. Repealed by Laws 2018, ch. 21, § 2.

26-26-105. Repealed by Laws 2018, ch. 21, § 2.

26-26-106. Repealed by Laws 2018, ch. 21, § 2.

26-26-107. Repealed by Laws 2018, ch. 21, § 2.

26-26-108. Repealed by Laws 2018, ch. 21, § 2.

26-26-109. Repealed by Laws 2018, ch. 21, § 2.

26-26-110. Repealed by Laws 2018, ch. 21, § 2.

26-26-111. Repealed by Laws 2018, ch. 21, § 2.

26-26-112. Repealed by Laws 2018, ch. 21, § 2.

26-26-113. Repealed by Laws 2018, ch. 21, § 2.

26-26-114. Repealed by Laws 2018, ch. 21, § 2.

26-26-115. Repealed by Laws 2018, ch. 21, § 2.

26-26-116. Repealed by Laws 2018, ch. 21, § 2.

26-26-117. Repealed by Laws 2018, ch. 21, § 2.

26-26-118. Repealed by Laws 2018, ch. 21, § 2.

26-26-119. Repealed by Laws 2018, ch. 21, § 2.

26-26-120. Repealed by Laws 2018, ch. 21, § 2.

26-26-121. Repealed by Laws 2018, ch. 21, § 2.

26-26-122. Repealed by Laws 2018, ch. 21, § 2.

26-26-123. Repealed by Laws 2018, ch. 21, § 2.

26-26-124. Repealed by Laws 2018, ch. 21, § 2.

26-26-125. Repealed by Laws 2018, ch. 21, § 2.

26-26-126. Repealed by Laws 2018, ch. 21, § 2.

26-26-127. Repealed by Laws 2018, ch. 21, § 2.

26-26-128. Repealed by Laws 2018, ch. 21, § 2.

26-26-129. Repealed by Laws 2018, ch. 21, § 2.

26-26-130. Repealed by Laws 2018, ch. 21, § 2.

26-26-131. Repealed by Laws 2018, ch. 21, § 2.

CHAPTER 27 - RECIPROCAL INSURERS

26-27-101. Definitions.

(a) As used in this chapter:

(i) "Attorney" means the attorney-in-fact of a reciprocal insurer and may be an individual, firm or corporation;

(ii) "Reciprocal insurance" means insurance resulting from an interexchange among persons, known as "subscribers", of reciprocal agreements of indemnity, the interexchange being carried out through an "attorney-in-fact" common to all the persons;

(iii) "Reciprocal insurer" means an unincorporated aggregation of subscribers operating individually and collectively through an attorney-in-fact to provide reciprocal insurance among themselves.

26-27-102. Scope and applicability of chapter; existing insurers.

(a) All authorized reciprocal insurers are governed by those sections of this chapter not expressly made applicable to domestic reciprocals.

(b) Authorized reciprocal insurers shall:

(i) Comply with this chapter;

(ii) Make any amendments to their subscribers' agreement, power of attorney policies and other documents and accounts not consistent with this chapter; and

(iii) Perform any other acts required for compliance.

26-27-103. Insuring powers.

(a) A reciprocal insurer, upon qualifying therefor as provided by this code, may transact any kind of insurance defined by this code, other than life or title insurances.

(b) A reciprocal insurer may purchase reinsurance upon the risk of any subscriber and may grant reinsurance as to any kind of insurance it is authorized to transact directly.

26-27-104. Name; power to sue or be sued.

(a) A reciprocal insurer shall:

(i) Have and use a business name, which shall include the word "reciprocal", "interinsurer", "interinsurance", "exchange", "underwriters", "underwriting" or "association";

(ii) Sue and be sued in its own name.

26-27-105. Attorney deemed not doing business in state; subscribers and attorney comprise single entity.

(a) The attorney of a foreign or alien reciprocal insurer, which insurer is authorized to transact insurance in this state, is not, by virtue of discharge of its duties as attorney with respect to the insurer's transactions in this state, considered to be doing business in this state within the meaning of any laws of this state applying to foreign persons, firms or corporations.

(b) The subscribers and the attorney-in-fact comprise a reciprocal insurer and a single entity for the purposes of chapter 4 of this code as to all operations under the insurer's certificate of authority.

26-27-106. Surplus funds required.

(a) A domestic reciprocal insurer formed under this chapter, if it has otherwise complied with the applicable

provisions of this code, may be authorized to transact insurance if it has and maintains surplus funds as follows:

(i) To transact property insurance, surplus funds of not less than three hundred thousand dollars ($300,000.00);

(ii) To transact casualty insurance, other than worker's compensation, surplus funds of not less than three hundred thousand dollars ($300,000.00);

(iii) To transact multiple lines insurance, surplus funds of not less than six hundred thousand dollars ($600,000.00).

(b) In addition to surplus required to be maintained under subsection (a) of this section, the insurer, when first authorized, shall have expendable surplus equal to not less than one-half (1/2) of the minimum amount of surplus required to be maintained.

(c) A domestic reciprocal insurer may be authorized to transact additional kinds of insurance if it has otherwise complied with the provisions of this code therefor and possesses and maintains surplus funds in an amount equal to the minimum capital stock and surplus required to be maintained by a stock insurer for authority to transact a like combination of kinds of insurance.

26-27-107. Organization; declaration.

(a) Twenty-five (25) or more persons domiciled in this state may organize a domestic reciprocal insurer and apply to the commissioner for a certificate of authority to transact insurance.

(b) The proposed attorney shall fulfill the requirements of and shall execute and file with the commissioner when applying for a certificate of authority, a declaration setting forth:

(i) The insurer's name;

(ii) The location of the insurer's principal office, which shall be the same as that of the attorney and shall be maintained within this state;

(iii) The kinds of insurance proposed to be transacted;

(iv) The names and addresses of the original subscribers;

(v) The designation and appointment of the proposed attorney and a copy of the power of attorney;

(vi) The names and addresses of the officers and directors of the attorney, if a corporation, or its members, if a firm;

(vii) The powers of the subscribers' advisory committee and the names and terms of office of the committee members;

(viii) That all monies paid to the reciprocal, after deducting therefrom any sum payable to the attorney, shall be held in the insurer's name and for the purposes specified in the subscribers' agreement;

(ix) A copy of the subscribers' agreement;

(x) A statement that each of the original subscribers has in good faith applied for insurance of a kind proposed to be transacted, and that the insurer has received from each such subscriber the full premium or premium deposit required for the policy applied for, for a term of not less than six (6) months at an adequate rate previously filed with and approved by the commissioner;

(xi) A statement of the insurer's financial condition, a schedule of its assets and a statement that the surplus required by W.S. 26-27-106 is on hand; and

(xii) A copy of each policy, endorsement and application form it then proposes to issue or use.

(c) The declaration specified in subsection (b) of this section shall be acknowledged by the attorney in the manner required for the acknowledgment of deeds.

26-27-108. Certificate of authority generally.

(a) A reciprocal insurer's certificate of authority shall be issued to its attorney in the insurer's name.

(b) The commissioner may refuse, suspend or revoke the certificate of authority, in addition to other grounds therefor, for failure of the attorney to comply with any provision of this code.

26-27-109. Power of attorney.

(a) The rights and powers of a reciprocal insurer's attorney are as provided in the power of attorney given it by the subscribers.

(b) The power of attorney shall set forth:

(i) That the attorney is empowered to accept service of process on behalf of the insurer in actions against the insurer upon contracts exchanged;

(ii) The powers of the attorney;

(iii) The general services to be performed by the attorney;

(iv) The maximum amount to be deducted from advance premiums or deposits to be paid to the attorney and the general items of expense, in addition to losses, to be paid by the insurer; and

(v) Except as to nonassessable policies, a provision for a contingent several liability of each subscriber in a specified amount, which shall not be less than one (1) nor more than ten (10) times the premium deposit stated in the policy.

(c) The power of attorney may:

(i) Provide for the right of substitution of the attorney and revocation of the power of attorney and rights thereunder;

(ii) Impose any restrictions upon the exercise of the power as are agreed upon by the subscribers;

(iii) Provide for the exercise of any right reserved to the subscribers directly or through their advisory committee; and

(iv) Contain any other lawful provisions deemed advisable.

(d) The terms of any power of attorney or agreement collateral thereto shall be reasonable and equitable, and no power or agreement shall be used or be effective in this state until approved by the commissioner.

26-27-110. Modifications of subscribers' agreement or power of attorney.

Modifications of the terms of the subscribers' agreement or of the power of attorney of a domestic reciprocal insurer shall be made jointly by the attorney and the subscribers' advisory committee. No modification is effective retroactively, nor does any modification affect any insurance contract issued prior to the modification.

26-27-111. Attorney's bond; generally.

(a) Concurrently with the filing of the declaration provided for in W.S. 26-27-107, the attorney of a domestic reciprocal insurer shall file with the commissioner a bond in favor of this state for the benefit of all persons damaged as a result of breach by the attorney of the conditions of his bond as set forth in subsection (b) of this section. The bond shall be executed by the attorney and by an authorized corporate surety, subject to the commissioner's approval.

(b) The bond shall be in the penal sum of twenty-five thousand dollars ($25,000.00), aggregate in form, conditioned that the attorney will faithfully account for all the insurer's monies and other property coming into his hands and that he will not withdraw or appropriate to his own use from the insurer's funds, any monies or property to which he is not entitled under the power of attorney.

(c) The bond shall provide that it is not subject to cancellation unless thirty (30) days advance notice in writing of cancellation is given both the attorney and the commissioner.

26-27-112. Attorney's bond; deposit instead of bond.

Instead of the bond required under W.S. 26-27-111, the attorney may maintain on deposit through the office of the commissioner, a like amount in cash or in value of securities qualified under

this code as insurers' investments and subject to the same conditions as the bond.

26-27-113. Attorney's bond; action on bond; deposit of amounts recovered; total aggregate liability.

Action on the attorney's bond or to recover against any deposit made instead of a bond may be brought at any time by one (1) or more subscribers suffering loss through a violation of its conditions, or by a receiver or liquidator of the insurer. Amounts recovered on the bond shall be deposited in and become part of the insurer's funds. The total aggregate liability of the surety is limited to the amount of the bond's penalty.

26-27-114. Service of process; judgments.

(a) Legal process shall be served upon a domestic reciprocal insurer by serving the insurer's attorney at his principal offices or by serving the commissioner as the insurer's process agent under W.S. 26-3-121 and 26-3-122.

(b) Any judgment based upon legal process so served is binding upon each of the insurer's subscribers as their individual interests may appear, but in an amount not exceeding their individual contingent liabilities, if any, the same as though personal service of process was had upon each subscriber.

26-27-115. Advances to insurer.

The attorney or other parties may advance to a domestic reciprocal insurer upon reasonable terms any funds it requires in its operations. Any advanced funds shall not be treated as a liability of the insurer, and, except upon liquidation of the insurer, shall not be withdrawn or repaid except out of the insurer's realized earned surplus in excess of its minimum required surplus. No withdrawal or repayment shall be made without the commissioner's advance approval. This section does not apply to bank loans or to other loans made upon security.

26-27-116. Annual statement.

(a) A reciprocal insurer's annual statement shall be made and filed by its attorney.

(b) The statement shall be supplemented by any information the commissioner requires relative to the attorney's affairs and transactions.

26-27-117. Determining financial condition of reciprocal insurer.

(a) In determining the financial condition of a reciprocal insurer the commissioner shall apply the rules set forth in the most recent National Association of Insurance Commissioners' accounting practices and procedures manual.

(i) Repealed By Laws 2001, Ch. 9, § 2.

(ii) Repealed By Laws 2001, Ch. 9, § 2.

(iii) Repealed By Laws 2001, Ch. 9, § 2.

(iv) Repealed By Laws 2001, Ch. 9, § 2.

(v) Repealed By Laws 2001, Ch. 9, § 2.

(vi) Repealed By Laws 2001, Ch. 9, § 2.

(vii) Repealed By Laws 2001, Ch. 9, § 2.

26-27-118. Who may be subscribers.

(a) Individuals, partnerships and corporations of this state may apply, enter into agreement for and hold policies or contracts in or with and be a subscriber of any domestic, foreign or alien reciprocal insurer. Any corporation organized under the laws of this state, in addition to the rights, powers, and franchises specified in its articles of incorporation, may exchange insurance contracts through the reciprocal insurer. The right to exchange the contracts is incidental to the purposes for which the corporations are organized and is as fully granted as the rights and powers expressly conferred upon those corporations.

(b) Any governmental entity, board, association, estate, trustee or fiduciary is authorized to exchange nonassessable reciprocal interinsurance contracts with any other governmental entity, board, association, estate, trustee or fiduciary and with individuals, partnerships and corporations to the same extent that individuals, partnerships and corporations are authorized to exchange reciprocal interinsurance contracts. Any officer, representative, trustee, receiver, or legal representative of any subscriber specified in this subsection is recognized as acting for or on its behalf for the purpose of the

contract but is not personally liable upon the contract by reason of acting in that representative capacity.

26-27-119. Subscribers' advisory committee.

(a) The advisory committee of a domestic reciprocal insurer exercising the subscribers' rights shall be selected under any rules the subscribers adopt.

(b) Not less than two-thirds (2/3) of the committee shall be subscribers other than the attorney, or any person employed by, representing or having a financial interest in the attorney.

(c) The committee shall:

(i) Supervise the insurer's finances;

(ii) Supervise the insurer's operations to the extent to assure conformity with the subscribers' agreement and power of attorney;

(iii) Procure the audit of the insurer's and the attorney's accounts and records at the insurer's expense; and

(iv) Have any additional powers and functions as the subscribers' agreement confers.

26-27-120. Subscribers' liability; generally.

(a) Except as to a nonassessable policy, the liability of each subscriber for the reciprocal insurer's obligations is an individual, several and proportionate liability and not a joint liability.

(b) Except as to a nonassessable policy, each subscriber has a contingent assessment liability in the amount provided for in the power of attorney or in the subscribers' agreement, for payment of actual losses and expenses incurred while his policy is in force. The contingent liability may be at the rate of not less than one (1) nor more than ten (10) times the premium or premium deposit stated in the policy, and the maximum aggregate contingent liability shall be computed in the manner set forth in W.S. 26-27-124.

(c) Each assessable policy the insurer issues shall contain a statement of the contingent liability, set in type of the same prominence as the insuring clause.

26-27-121. Subscribers' liability; liability upon judgment.

(a) No action shall lie against any subscriber upon any obligation claimed against the insurer until a final judgment is obtained against the insurer and remains unsatisfied for thirty (30) days.

(b) Any judgment specified in this section is binding upon each subscriber only in the proportion as his interests appear and in an amount not exceeding his contingent liability, if any.

26-27-122. Assessment of subscribers.

(a) Upon advance approval by the subscribers' advisory committee and the commissioner, the attorney may levy assessments upon subscribers of a domestic reciprocal insurer liable therefor under the terms of their policies. The commissioner may also levy assessments upon subscribers in liquidation of the insurer.

(b) Each subscriber's share of a deficiency for which an assessment is made, but not exceeding in any case his aggregate contingent liability as computed in accordance with W.S. 26-27-124, shall be computed by applying to the premium earned on the subscriber's policy or policies during the period to be covered by the assessment, the ratio of the total deficiency to the total premiums earned during that period upon all policies subject to the assessment.

(c) In computing the earned premiums for the purposes of this section, the gross premium the insurer receives for the policy shall be used as a base, deducting therefrom solely charges not recurring upon the policy renewal or extension.

(d) No subscriber shall have an offset against any assessment for which he is liable, because of any claim for unearned premium or losses payable.

26-27-123. Time limit for assessments.

(a) Each subscriber of a domestic reciprocal insurer having contingent liability is liable for and shall pay his share of any assessment, as computed and limited in accordance with this chapter, if:

(i) While his policy is in force or within one (1) year after its termination, he is notified by either the attorney or the commissioner of his intentions to levy an assessment; or

(ii) An order to show cause why a receiver, conservator, rehabilitator or liquidator of the insurer should not be appointed is issued while his policy is in force or within one (1) year after its termination.

26-27-124. Aggregate liability.

No one (1) policy or subscriber as to that policy shall be assessed or charged with an aggregate of contingent liability, as to obligations incurred by a domestic reciprocal insurer in any one (1) calendar year, in excess of the amount provided for in the power of attorney or in the subscribers' agreement, computed solely upon premium earned on that policy during that year.

26-27-125. Nonassessable policies.

(a) If a reciprocal insurer has a surplus of assets over all liabilities at least equal to the minimum capital stock and surplus required to be maintained by a domestic stock insurer authorized to transact like kinds of insurance, upon application of the attorney and as approved by the subscribers' advisory committee, the commissioner shall issue his certificate authorizing the insurer to extinguish the contingent liability of subscribers under its policies then in force in this state and to omit provisions imposing contingent liability in all policies delivered or issued for delivery in this state for as long as all the surplus remains unimpaired.

(b) If the surplus is impaired, the commissioner shall immediately revoke the certificate. The revocation does not render subject to contingent liability any policy then in force and for the remainder of the period for which the premium has been paid. After revocation no policy shall be issued or renewed without providing for the subscriber's contingent assessment liability.

(c) The commissioner shall not authorize a domestic reciprocal insurer to extinguish the contingent liability of any of its subscribers or in any of its policies to be issued, unless it qualifies to and does extinguish the liability of all its subscribers and in all the policies for all kinds of

insurance it transacts. If required by the laws of another state in which the insurer is transacting insurance as an authorized insurer, the insurer may issue policies providing for the contingent liability of those of its subscribers as acquire the policies in that state, and need not extinguish the contingent liability applicable to policies previously in force in that state.

26-27-126. Distribution of savings.

A reciprocal insurer may return to its subscribers any unused premiums, savings or credits accruing to their accounts. Any such distribution shall not unfairly discriminate between classes of risks, or policies, or between subscribers, but this does not prevent retrospective rating, nor distribution on a retrospective plan.

26-27-127. Distribution of subscribers' share of assets upon liquidation.

Upon the liquidation of a domestic reciprocal insurer, its assets remaining after discharge of its indebtedness and policy obligations, the return of any contributions of the attorney or other persons to its surplus made as provided in W.S. 26-27-115, and the return of any unused premium, savings or credits then standing on subscribers' accounts, shall be distributed to its subscribers who were subscribers within the twelve (12) months immediately prior to the last termination of its certificates of authority, according to any reasonable formula the commissioner approves.

26-27-128. Merger or conversion.

(a) A domestic reciprocal insurer may merge with another reciprocal insurer or be converted to a stock or mutual insurer, upon affirmative vote of not less than two-thirds (2/3) of its subscribers who vote on the question pursuant to proper notice and the commissioner's approval of the merger terms.

(b) Any stock or mutual insurer specified in subsection (a) of this section is subject to the same capital or surplus requirements and has the same rights as a like domestic insurer transacting like kinds of insurance.

(c) The commissioner shall not approve any plan for merger or conversion which is inequitable to subscribers, or which, if for conversion to a stock insurer, does not give each subscriber

preferential right to acquire stock of the proposed insurer proportionate to his interest in the reciprocal insurer as determined in accordance with W.S. 26-27-127 and a reasonable length of time within which to exercise that right.

26-27-129. Impaired reciprocals; liquidation.

(a) If a reciprocal insurer's assets are at any time insufficient to discharge its liabilities, other than any liability because of funds contributed by the attorney or others, and to maintain the required surplus, its attorney shall immediately make up the deficiency or levy an assessment upon the subscribers for the amount needed to make up the deficiency, subject to the limitation set forth in the power of attorney or policy.

(b) If the attorney fails to make up the deficiency or to make the assessment within thirty (30) days after the commissioner orders him to do so, or if the deficiency is not fully made up within sixty (60) days after the date the assessment is made, the insurer is deemed insolvent and shall be proceeded against as authorized by this code.

(c) If an insurer's liquidation is ordered, an assessment shall be levied upon the subscribers in an amount, subject to limits as provided by this chapter, the commissioner determines to be necessary to discharge all the insurer's liabilities, exclusive of any funds contributed by the attorney or other persons, but including the reasonable liquidation cost.

CHAPTER 28 - REHABILITATION AND LIQUIDATION

26-28-101. Definitions.

(a) As used in this chapter:

(i) "Ancillary state" means any state other than a domiciliary state;

(ii) "Delinquency proceeding" means any proceeding commenced against an insurer pursuant to this chapter for the purpose of liquidating, rehabilitating, reorganizing or conserving the insurer;

(iii) "Domiciliary state" means the state in which an insurer is incorporated or organized, or in the case of an insurer incorporated or organized in a foreign country, the

state in which the insurer, being authorized to do business therein, has at the commencement of delinquency proceedings, the largest amount of its assets held in trust and assets held on deposit for the benefit of its policyholders or policyholders and creditors in the United States, and that insurer is deemed to be domiciled in that state;

(iv) "Foreign country" means territory not in any state;

(v) "General assets" means:

(A) All property not specifically mortgaged, pledged, deposited or otherwise encumbered for the security or benefit of specified persons or limited classes of persons and as to any specifically encumbered property, all such property or its proceeds in excess of the amount necessary to discharge the sums secured thereby; and

(B) Assets held in trust and assets held on deposit for the security or benefit of all policyholders or all policyholders and creditors in the United States.

(vi) "Impairment" or "insolvency" means that an insurer does not possess assets at least equal to all liabilities and required reserves together with its total issued and outstanding capital stock if a stock insurer, or the minimum surplus if a mutual or reciprocal insurer required by this code to be maintained for the kinds of insurance it is then authorized to transact and the capital or surplus is deemed impaired and the insurer is deemed insolvent;

(vii) "Insurer" means any person, firm, corporation, association or aggregation of persons doing an insurance business and subject to the insurance supervisory authority of, or to liquidation, rehabilitation, reorganization or conservation by the commissioner or the equivalent insurance supervisory official of another state, including health organizations regulated under W.S. 26-48-201 through 26-48-212;

(viii) "Preferred claim" means any claim with respect to which the law of the state or of the United States accords priority of payments from the insurer's general assets;

(ix) "Receiver" means receiver, liquidator, rehabilitator or conservator as the context requires;

(x) "Reciprocal state" means any state other than this state in which in substance and effect the provisions of the Uniform Insurers Liquidation Act, as defined in W.S. 26-28-119, are in force, including the provisions requiring that the commissioner of insurance or equivalent supervisory official be the receiver of a delinquent insurer;

(xi) "Secured claim" means:

(A) Any claim secured by mortgage, trust deed, pledge, deposit as security, escrow or otherwise, but not including special deposit claim or claims against general assets; and

(B) Claims which more than four (4) months prior to the commencement of delinquency proceeding in the state of the insurer's domicile have become liens upon specific assets by reason of judicial process.

(xii) "Special deposit claim" means any claim secured by a deposit made pursuant to statute for the security or benefit of a limited class of persons, but not including any general assets;

(xiii) "State" means any state of the United States, the District of Columbia and Puerto Rico.

26-28-102. Delinquency proceedings; jurisdiction; venue; change of venue; exclusiveness of remedy; appeal.

(a) The district court has original jurisdiction of any delinquency proceeding under this chapter and any court with jurisdiction may make any necessary or proper orders to carry out the purposes of this chapter.

(b) The venue of delinquency proceedings against a domestic insurer is in the county of the insurer's principal place of business. The venue of delinquency proceedings against foreign and alien insurers is in the district court for Laramie county.

(c) At any time after the commencement of a proceeding under this chapter, the commissioner may apply to the court for an order changing the venue of and removing the proceeding to Laramie county or to any other county of this state in which he deems that the proceeding may be most economically and efficiently conducted.

(d) Delinquency proceedings pursuant to this chapter constitute the sole and exclusive method of liquidating, rehabilitating, reorganizing or conserving an insurer, and no court shall entertain a petition for a commencement of such proceedings unless the petition is filed in the name of the state on the relation of the commissioner.

(e) An appeal shall lie to the supreme court from any order:

(i) Granting or refusing rehabilitation, liquidation or conservation; and

(ii) In delinquency proceedings having the character of a final order as to the particular portion of the proceedings embraced therein.

26-28-103. Delinquency proceedings; commencement.

The commissioner shall commence any delinquency proceedings by application to the court for an order directing the insurer to show cause why the commissioner should not have the relief prayed for. On the return of the order to show cause, and after a full hearing, the court shall either deny the application or grant the application, together with any other relief as the nature of the case and the interests of the policyholders, creditors, stockholders, members, subscribers or the public require.

26-28-104. Injunctions.

(a) Upon application by the commissioner for an order to show cause, or at any time thereafter, the court, without notice, may issue an injunction restraining the insurer, its officers, directors, stockholders, members, subscribers, agents and all other persons from the transaction of its business or the waste or disposition of its property until further court order.

(b) The court, at any time during a proceeding under this chapter, may issue any other injunctions or orders deemed necessary to prevent interference with the:

(i) Commissioner or the proceeding;

(ii) Waste of the insurer's assets;

(iii) Commencement or prosecution of any actions;

(iv) Obtaining of preferences, judgments, attachments or other liens; or

(v) Making of any levy against the insurer or against its assets or any part thereof.

(c) Notwithstanding any other provision of law, no bond is required of the commissioner as a prerequisite for the issuance of any injunction or restraining order pursuant to this section.

26-28-105. Grounds for receivership; rehabilitation of domestic insurer.

(a) The commissioner may apply to the court for an order appointing him as receiver of and directing him to rehabilitate a domestic insurer if the insurer:

(i) Is impaired or insolvent or is in unsound or such other condition or using such methods and practices in the conduct of its business as to render its further transaction of insurance hazardous or injurious to its policyholders;

(ii) Refuses to submit any of its books, records, accounts or affairs to reasonable examination by the commissioner;

(iii) Conceals or removes records or assets or otherwise violates W.S. 26-24-129;

(iv) Fails to comply with the commissioner's order to make good an impairment of capital or surplus or both;

(v) Transfers or attempts to transfer substantially its entire property or business, or enters into any transaction the effect of which is to merge substantially its entire property or business in that of any other insurer without first obtaining the commissioner's written approval;

(vi) Willfully violates its charter or articles of incorporation or any law of this state;

(vii) Has an officer, director or manager who refuses to be examined under oath concerning its affairs, for which purposes the commissioner may conduct and enforce by all

appropriate and available means any such examination under oath in any other state or territory of the United States in which the officer, director or manager may then presently be, to the full extent permitted by the laws of the other state or territory;

(viii) Is the subject of an application for the appointment of a receiver, trustee, custodian or sequestrator of the insurer or its property otherwise than pursuant to this code, but only if the appointment has been made or is imminent and its effect is or would be to oust the courts of this state of jurisdiction under this chapter;

(ix) Consents to a receivership order through a majority of its directors, stockholders, members or subscribers; or

(x) Fails to pay a final judgment rendered against it in this state upon any insurance contract issued or assumed by it, within thirty (30) days after the judgment is final, or within thirty (30) days after the time for taking an appeal expires or within thirty (30) days after dismissal of an appeal before final termination, whichever date is later.

26-28-106. Grounds for receivership; liquidation.

(a) The commissioner may apply to the court for an order appointing him as receiver, if his appointment as receiver is not then in effect, and directing him to liquidate the business of a domestic insurer or of the United States branch of an alien insurer having trusteed assets in this state, regardless of whether or not there has been a prior order directing him to rehabilitate the insurer, upon any of the grounds specified in W.S. 26-28-105, or if the insurer:

(i) Does not transact business for a period of one (1) year; or

(ii) Is insolvent and has commenced voluntary liquidation or dissolution or attempts to:

(A) Commence or prosecute any action or proceeding to liquidate its business or affairs;

(B) Dissolve its corporate charter; or

(C) Procure the appointment of a receiver, trustee, custodian or sequestrator under any law except this code.

26-28-107. Grounds for conservation; foreign insurers or alien insurers.

(a) The commissioner may apply to the court for an order appointing him as receiver or ancillary receiver and directing him to conserve the assets within this state of a foreign or alien insurer upon:

(i) Any of the grounds specified in W.S. 26-28-105 or 26-28-106; or

(ii) The ground that the insurer's property has been sequestrated in its domiciliary sovereignty or in any other sovereignty; or

(iii) If an alien insurer, the ground that the insurer failed to comply, within the time the commissioner designated, with an order by the commissioner to make good an impairment of its trusteed funds.

26-28-108. Grounds for ancillary liquidation of foreign insurers.

The commissioner may apply to the court for an order appointing him as ancillary receiver of and directing him to liquidate the business of a foreign insurer having assets, business or claims in this state upon the appointment in the domiciliary state of that insurer of a receiver, liquidator, conservator, rehabilitator or other officer for the purpose of liquidating the business of that insurer.

26-28-109. Order of rehabilitation.

(a) An order to rehabilitate a domestic insurer shall direct the commissioner immediately to:

(i) Take possession of the insurer's property and conduct its business; and

(ii) Take any steps the court directs toward removal of the causes and conditions making rehabilitation necessary.

(b) If at any time the commissioner deems that further efforts to rehabilitate the insurer would be useless, he may apply to the court for an order of liquidation.

(c) The commissioner or any interested person, upon notice to the commissioner, may apply to the court for an order terminating the rehabilitation proceedings and permitting the insurer to resume possession of its property and the conduct of its business. No termination order shall be made or entered unless, after a hearing, the court determines that the purposes of the proceeding have been fully accomplished.

26-28-110. Order of liquidation.

(a) An order to liquidate the business of a domestic insurer shall direct the commissioner immediately to:

(i) Take possession of the insurer's property;

(ii) Liquidate the insurer's business;

(iii) Deal with the insurer's property and business in his own name as commissioner of insurance or in the insurer's name, as the court directs; and

(iv) Give notice to all creditors with claims against the insurer to present those claims.

(b) The commissioner may apply for and secure an order dissolving the corporate existence of a domestic insurer upon his application for an order of that insurer's liquidation or at any time after the order is granted.

26-28-111. Order of conservation or ancillary liquidation of foreign or alien insurer.

(a) An order to conserve a foreign or alien insurer's assets requires the commissioner immediately to take possession of the insurer's property within this state and to conserve it, subject to the court's further direction.

(b) An order to liquidate a foreign insurer's assets in this state requires the commissioner immediately to take possession of the insurer's property within this state and to liquidate it subject to the court's orders and with due regard to the rights and powers of the domiciliary receiver as provided in this chapter.

26-28-112. Conduct of delinquency proceedings; domestic and alien insurers.

(a) If under this chapter a receiver is to be appointed in delinquency proceedings for a domestic or alien insurer, the court shall appoint the commissioner as the receiver. The court shall order the commissioner immediately to take possession of the insurer's assets and to administer those assets under the court's orders.

(b) As a domiciliary receiver, the commissioner is vested by operation of law with the title to all of the insurer's property, contracts and right of action and all of its books and records, wherever located, as of the date of entry of the order directing him to rehabilitate or liquidate a domestic insurer or to liquidate the United States branch of an alien insurer domiciled in this state. The commissioner may recover and take possession of the insurer's property, contracts and right of action and its books and records, except that ancillary receivers in reciprocal states, as to assets located in their states, have the rights and powers prescribed in this chapter for ancillary receivers appointed in this state as to assets located in this state.

(c) The filing or recording of the order directing possession to be taken, or a certified copy thereof, in any office where instruments affecting title to property are required to be filed or recorded, imparts the same notice as is imparted by a deed, bill of sale or other evidence of title duly filed or recorded.

(d) The commissioner as domiciliary receiver is responsible for the proper administration of all assets coming into his possession or control. The court may require a bond from the commissioner or his deputies if deemed desirable for the protection of the assets.

(e) Upon taking possession of the insurer's assets, the domiciliary receiver, subject to the court's direction, immediately shall proceed to conduct the insurer's business or to take any steps authorized by this chapter for rehabilitating, liquidating or conserving the insurer's affairs or assets.

(f) In connection with delinquency proceedings, the commissioner may appoint one (1) or more special deputy commissioners to act for him and he may employ such counsel,

clerks and assistants as he deems necessary. The compensation of the special deputies, counsel, clerks or assistants and all expenses of taking possession of the insurer and of conducting the proceeding shall be fixed by the receiver, subject to the court's approval, and shall be paid out of the insurer's funds or assets. Within the limits of duties imposed upon them, special deputies have the powers of the receiver and, in the exercise of those powers, are subject to all of the duties imposed upon the receiver with respect to the proceedings.

26-28-113. Conduct of delinquency proceedings; foreign insurers.

(a) If under this chapter an ancillary receiver is to be appointed in delinquency proceedings for an insurer not domiciled in this state, the court shall appoint the commissioner as ancillary receiver. The commissioner shall file a petition requesting the appointment on the grounds set forth in W.S. 26-28-108 if:

(i) He finds the insurer has sufficient assets located in this state to justify the appointment of an ancillary receiver; or

(ii) Ten (10) or more persons resident in this state having claims against the insurer file a petition with the commissioner requesting the appointment of an ancillary receiver.

(b) The domiciliary receiver for the purpose of liquidating an insurer domiciled in a reciprocal state is vested by operation of law with the title to all of the insurer's property, contracts and rights of action and all of its books and records located in this state. The domiciliary receiver has the immediate right to recover balances due from local agents, to obtain possession of any of the insurer's books and records found in this state and to recover the insurer's other assets located in this state, except that upon the appointment of an ancillary receiver in this state, the ancillary receiver, during the ancillary receivership proceedings, has sole right to recover the other assets. The ancillary receiver, as soon as practicable, shall liquidate from the securities those special deposit claims and secured claims which are proved and allowed in the ancillary proceedings in this state and shall pay the necessary expenses of the proceedings. He shall promptly transfer all remaining assets to the domiciliary receiver. Subject to the provisions of this subsection, the ancillary

receiver and his deputies have the same powers and are subject to the same duties with respect to the administration of the assets as a receiver of an insurer domiciled in this state.

(c) The domiciliary receiver of an insurer domiciled in the reciprocal state may sue in this state to recover any of the insurer's assets to which he is entitled under the laws of this state.

26-28-114. Claims of nonresidents against domestic insurers.

(a) In a delinquency proceeding begun in this state against a domestic insurer, claimants residing in reciprocal states may file claims either with the ancillary receivers, if any, in their states or with the domiciliary receiver. The claims shall be filed on or before the last date fixed for the filing of claims in the domiciliary delinquency proceedings.

(b) Controverted claims belonging to claimants residing in reciprocal states may either:

(i) Be proved in this state; or

(ii) If ancillary proceedings have been commenced in the reciprocal states, be proved in those proceedings.

(c) If a claimant elects to prove his claim in ancillary proceedings and if notice of the claim and opportunity to appear and be heard is afforded the domiciliary receiver of this state, as provided in W.S. 26-28-115 with respect to ancillary proceedings in this state, the final allowance of the claim by the courts in the ancillary state shall be accepted in this state as conclusive as to its amount and shall also be accepted as conclusive as to its priority, if any, against special deposits or other security located within the ancillary state.

26-28-115. Claims against foreign insurers.

(a) In a delinquency proceeding in a reciprocal state against an insurer domiciled in that state, claimants against the insurer who reside within this state may file claims either with the ancillary receiver, if any, appointed in this state, or with the domiciliary receiver. The claims shall be filed on or before the last date fixed for the filing of claims in the domiciliary delinquency proceedings.

(b) Controverted claims belonging to claimants residing in this state may either:

(i) Be proved in the domiciliary state as provided by the laws of that state; or

(ii) If ancillary proceedings have been commenced in this state, be proved in those proceedings.

(c) If any claimant elects to prove his claim in this state, he shall file his claim with the ancillary receiver and shall give notice in writing to the receiver in the domiciliary state, either by registered mail or by personal service at least forty (40) days prior to the date set for hearing. The notice shall contain a concise statement of the amount of the claim, the facts on which the claim is based and the priorities asserted, if any. If the domiciliary receiver within thirty (30) days after the giving of the notice gives notice in writing to the ancillary receiver and to the claimant, either by registered mail or by personal service, of his intention to contest the claim, he is entitled to appear or to be represented in any proceeding in this state involving the claim adjudication. The final allowance of the claim by the courts of this state shall be accepted as conclusive as to its amount and shall also be accepted as conclusive as to its priority, if any, against special deposits or other security located within this state.

26-28-116. Claims generally.

(a) All claims against an insurer against which delinquency proceedings are in progress shall set forth in reasonable detail the amount of the claim, or the basis upon which the amount can be ascertained, the facts upon which the claim is based and the priorities asserted, if any. All such claims shall be verified by the affidavit of the claimant, or someone authorized to act on his behalf and having knowledge of the facts, and shall be supported by documents material thereto.

(b) All claims filed in this state shall be filed with the receiver, whether domiciliary or ancillary, in this state, on or before the last date for filing as specified in this chapter.

(c) Within ten (10) days from the date of receipt of any claim, or within any further period as the court, for good cause shown, determines, the receiver shall report the claim to the court, specifying in the report his recommendation with respect to the action to be taken thereon. Upon receipt of the report,

the court shall fix a time for hearing the claim and shall direct that the claimant or the receiver, as the court specifies, shall give notice as the court determines to those persons as appear to the court to be interested therein. The notices shall specify the time and place of the hearing and shall concisely state the amount and nature of the claim, the priorities asserted, if any, and the recommendation of the receiver with reference thereto.

(d) All interested persons may appear at the hearing, and the court shall enter an order allowing, allowing in part or disallowing the claim. The order is appealable.

26-28-117. Priority of certain claims.

(a) In a delinquency proceeding against an insurer domiciled in this state, claims owing to residents of ancillary states are preferred claims if like claims are preferred under the laws of this state. All claims owing to residents or nonresidents shall be given equal priority of payment from general assets regardless of where the assets are located.

(b) In a delinquency proceeding against an insurer domiciled in a reciprocal state, claims owing to residents of this state shall be preferred if like claims are preferred by the laws of that state.

(c) The owners of special deposit claims against an insurer for which a receiver is appointed in this or any other state shall be given priority against their special deposits in accordance with the provisions of the statutes governing the creation and maintenance of the deposits. If there is a deficiency in any deposit so that the claims secured thereby are not fully discharged, the claimants may share in the general assets, but that sharing shall be deferred until general creditors, and also claimants against other special deposits who have received smaller percentages from their special deposits, have been paid percentages of their claims equal to the percentage paid from the special deposit.

(d) The owner of a secured claim against an insurer for which a receiver has been appointed in this or any other state may surrender his security and file his claim as a general creditor, or the claim may be discharged by resort to the security, in which case the deficiency, if any, shall be treated as a claim against the insurer's general assets on the same basis as claims of unsecured creditors. If the amount of the

deficiency is adjudicated in ancillary proceedings as provided in this chapter, or if it is adjudicated by a court of competent jurisdiction in proceedings in which the domiciliary receiver has had notice and opportunity to be heard, the amounts are conclusive. Otherwise the amount shall be determined in the delinquency proceeding in a domiciliary state.

26-28-118. Attachment, garnishment or execution during pendency of delinquency proceedings.

During the pendency of delinquency proceedings in this or any reciprocal state, no action or proceeding in the nature of an attachment, garnishment or execution shall be commenced or maintained in the courts of this state against the delinquent insurer or its assets. Any lien obtained by any such action or proceeding within four (4) months prior to the commencement of any delinquency proceeding or at any time thereafter is void as against any rights arising in the delinquency proceeding.

26-28-119. Sections constituting Uniform Insurers Liquidation Act; interpretation and construction.

(a) W.S. 26-28-101(a)(i) through (v) and (vii) through (xiii), 26-28-103, 26-28-104 and 26-28-112 through 26-28-119 constitute and may be referred to as the Uniform Insurers Liquidation Act.

(b) The Uniform Insurers Liquidation Act shall be so interpreted and construed as to carry out its general purpose to make uniform the law of those states that enact it. To the extent that its provisions when applicable conflict with other provisions of this chapter, the provisions of that act control.

26-28-120. Deposit of monies collected.

The monies the commissioner collects in a proceeding under this chapter shall be deposited in one (1) or more state or national banks, savings banks or trust companies. In case of insolvency or voluntary or involuntary liquidation of any such depository which is an institution organized and supervised under the laws of this state, the deposits are entitled to priority of payment on an equality with any other priority given by the banking laws of this state. The commissioner may deposit the monies or any part thereof in a national bank or trust company as a trust fund.

26-28-121. Commissioner exempt from payment of fees.

(a) The commissioner is not required to pay any fee to any public officer in this state for filing, recording, issuing a transcript or certificate or authenticating any paper or instrument pertaining to the commissioner's exercise of any of the powers or duties conferred upon him under this chapter, whether or not:

(i) The paper or instrument is executed by the commissioner or his deputies, employees or attorneys of record; and

(ii) It is connected with the commencement of any action or proceeding by or against the commissioner or with subsequent conduct of that action or proceeding.

26-28-122. Power of commissioner to borrow on pledge of assets.

(a) For the purpose of facilitating the rehabilitation, liquidation, conservation or dissolution of an insurer pursuant to this chapter, the commissioner, subject to court approval, may:

(i) Borrow money and execute, acknowledge and deliver notes or other evidences of indebtedness therefor and secure the repayment of the notes or other evidences of indebtedness by the mortgage, pledge, assignment, transfer in trust or hypothecation of any of the insurer's property; and

(ii) Take any other action necessary and proper to consummate any such loan and to provide for the repayment of that loan.

(b) The commissioner has no obligation personally or in his official capacity to repay any loan made pursuant to this section.

26-28-123. Date rights fixed on liquidation.

The rights and liabilities of the insurer and of its creditors, policyholders, stockholders, members, subscribers and any other persons interested in its estate, unless the court otherwise directs, shall be fixed as of the date on which the order directing the insurer's liquidation is filed in the office of the clerk of the court which made the order, subject to the

provisions of this chapter with respect to the rights of claimants holding contingent claims.

26-28-124. Voidable transfers.

(a) Any transfer of, or lien upon, an insurer's property is voidable if it is:

(i) Made or created within four (4) months prior to the granting of an order to show cause under this chapter, with the intent of giving to any creditor a preference or of enabling him to obtain a greater percentage of his debt than any other creditor of the same class; and

(ii) Accepted by the creditor having reasonable cause to believe that the preference will occur.

(b) Any director, officer, employee, stockholder, member, subscriber and any other person acting on the insurer's behalf who is involved in any such act or deed and any person receiving thereby any of the insurer's property or the benefit of that property is personally liable therefor and is accountable to the commissioner.

(c) The commissioner as a receiver in any proceeding under this chapter may avoid any transfer of or lien upon an insurer's property which any creditor, stockholder, subscriber or member of the insurer might have avoided and may recover the property so transferred unless the person is a bona fide holder for value prior to the date of the entering of an order to show cause under this chapter. The property or its value may be recovered from anyone who receives it except a bona fide holder for value as specified in this subsection.

26-28-125. Priority of distribution of an insolvent insurer's assets.

(a) The priorities of distribution of general assets from the company's estate is as follows:

(i) The costs and expenses of the administration, insolvency, liquidation and rehabilitation, including the claims handling expenses of the Wyoming Insurance Guaranty Association and of any similar organization in any other state as prescribed in W.S. 26-31-101 through 26-31-117;

(ii) Wages actually owing to employees, other than officers of insurers, for services rendered within three (3) months prior to the date of commencement of a proceeding against the insurer under this chapter, but not exceeding one thousand dollars ($1,000.00) to each employee and secured claims, including claims for taxes and debts due the federal or any state or local government which are secured by liens perfected prior to the commencement of delinquency proceedings;

(iii) Claims by policyholders, beneficiaries, insureds and liability claims against insureds covered under insurance policies and insurance contracts issued by the company, as set forth in W.S. 26-28-114 through 26-28-117 and claims of the Wyoming Insurance Guaranty Association and any similar organization in another state as prescribed in W.S. 26-31-110;

(iv) All other claims of general creditors not falling within any other priority under this section, including claims for taxes and debts due the federal government or any state or local government which are not secured claims;

(v) Claims of guarantee association certificate holders, guarantee capital shareholders and surplus note holders;

(vi) Proprietary claims of shareholders, members or other owners.

(b) Upon the issuance of an order of liquidation with a finding of insolvency against a domestic company, the commissioner shall apply to the court requesting authority to disburse funds to the Wyoming Insurance Guaranty Association out of the company's marshaled assets as funds become available in amounts equal to disbursements made by the association for claims handling expense and covered claims obligations on the presentation of evidence that the association made disbursements. The commissioner shall:

(i) In the application request authority to make disbursements to similar organizations in other states provided the Wyoming Insurance Guaranty Association is entitled to like payment under the laws of the similar organization's state of domicile with respect to insolvent companies domiciled in that state;

(ii) In determining the amounts available for disbursements to the Wyoming Insurance Guaranty Association and similar organizations in other states, reserve sufficient assets for the payment of the expenses of administration;

(iii) Establish procedures for the ratable allocation of disbursements to the Wyoming Insurance Guaranty Association and similar organizations in other states; and

(iv) Secure from the Wyoming Insurance Guaranty Association and each eligible similar organization in other states as a condition to advances in reimbursement of covered claims obligations an agreement to return to the commissioner on demand funds previously advanced as may be required to pay claims of secured creditors and claims falling within the priorities established in paragraphs (a)(ii) and (iii) of this section in accordance with such priorities.

26-28-126. Offsets.

(a) 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 debts shall be set off and the balance only shall be allowed or paid, except as provided in subsection (b) of this section.

(b) No offset shall be allowed in favor of any person specified in subsection (a) of this section if:

(i) The insurer's obligation to that person, at the date of the entry of any liquidation order or otherwise, as provided in W.S. 26-28-123, does not entitle him to share as a claimant in the insurer's assets;

(ii) The insurer's obligation to that person is purchased by or transferred to that person with a view of its being used as an offset; or

(iii) The obligation of that 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 insurer's capital stock.

26-28-127. Allowance of certain claims after insolvency; entry of liquidation order.

(a) No contingent and unliquidated claim shall share in a distribution of an insurer's assets if that insurer is adjudicated to be insolvent by an order made pursuant to this chapter, except that the claim shall be considered, if properly presented, and may be allowed to share if:

(i) The claim is absolute against the insurer on or before the last day for filing claims against the insurer's assets; or

(ii) There is a surplus and the liquidation is thereafter conducted upon the basis that the insurer is solvent.

(b) If an insurer is adjudicated to be insolvent, any person who has a cause of action against an insured of that insurer, under a liability insurance policy issued by the insurer, may file a claim in the liquidation proceeding, regardless of the fact that the claim is contingent, and the claim may be allowed if:

(i) It may be reasonably inferred from the proof presented upon the claim that the person would be able to obtain a judgment upon the cause of action against the insured;

(ii) The person furnishes suitable proof, unless the court for good cause shown otherwise directs, that no further valid claim against the insurer arising out of his cause of action other than those already presented can be made; and

(iii) The insurer's total liability to all claimants arising out of the same act of its insured is no greater than its maximum liability would be were it not in liquidation.

(c) No judgment against an insured taken after the date of entry of the liquidation order shall be considered in the liquidation proceedings as evidence of liability, or of the amount of damages. No judgment against an insured taken by default or by collusion prior to the entry of the liquidation order shall be considered as conclusive evidence in the liquidation proceedings, either of the liability of the insured to the person upon the cause of action or of the amount of damages to which the person is entitled.

(d) No claim of any secured claimant shall be allowed at a sum greater than the difference between the value of the claim without security and the value of the security itself as of the date of the entry of the order of liquidation or any other date

the court sets for determining rights and liabilities as provided in W.S. 26-28-123 unless the claimant surrenders his security to the commissioner, in which case the claim shall be allowed in the full amount for which it is valued.

26-28-128. Order of insolvency; time to file claims after insolvency order; payment of claims; procedure.

(a) If upon the entry of a liquidation order under this chapter or at any time thereafter during liquidation proceedings the insurer is not clearly solvent, the court, upon hearing after notice it deems proper, shall enter an order adjudging the insurer to be insolvent.

(b) After the entry of the order of insolvency, regardless of any prior notice given to creditors, the commissioner shall notify all persons who may have claims against the insurer to file the claims with him, at a place and within the time specified in the notice, or that the claims are forever barred. The time specified in the notice shall be as fixed by the court for filing of claims but not less than six (6) months after the entry of the insolvency order. The notice shall be given in a manner and for a reasonable period of time as the court orders.

(c) Any time after the last day fixed for the filing of proofs of claims in the liquidation of a domestic company, the court, upon the commissioner's application, may authorize him to declare out of the funds remaining in his hands, one (1) or more dividends upon all claims allowed in accordance with the priorities established in W.S. 26-28-125.

(d) If there has been no adjudication of insolvency, the commissioner shall pay all allowed claims in full in accordance with the priorities set forth in W.S. 26-28-125. The commissioner is not chargeable for any assets distributed to any claimant who fails to file a proper proof of claim before the distribution is made.

(e) If after an insolvency adjudication, a surplus is found to exist after the payment in full of all allowed claims falling within the priorities set forth in W.S. 26-28-125(a)(i) through (iv) and which were filed prior to the last date fixed for the filing thereof, and after the setting aside of a reserve for all additional costs and expenses of the proceeding, the court shall set a new date for the filing of claims. After the expiration of the new date, all allowed claims filed on or before the new date together with all previously allowed claims

falling within the priorities set forth in W.S. 26-28-125(a)(v) and (vi) shall be paid in accordance with the priorities set forth in W.S. 26-28-125.

(f) The commissioner may deposit to his credit any dividends which he holds and remain unclaimed or unpaid for six (6) months after the final distribution order. The dividends shall be held in trust for the person entitled thereto, but that person is not entitled to any interest on the deposit. All such deposits are entitled to priority of payment in case of the depository's insolvency or voluntary or involuntary liquidation on an equal basis with any other priority given by the banking law. Those funds together with interest, if any, paid or credited thereon, remaining and unclaimed in the commissioner's hands in trust after two (2) years are presumed abandoned, shall be reported and delivered to the state treasurer and are subject to W.S. 9-5-203.

26-28-129. Report and petition for assessment.

(a) Within three (3) years after the date of the entry of a rehabilitation or liquidation order of a domestic mutual insurer or a domestic reciprocal insurer, the commissioner may make and file his report and petition to the court setting forth:

(i) The reasonable value of the insurer's assets;

(ii) The insurer's liabilities to the extent thus far ascertained by the commissioner;

(iii) The aggregate amount of the assessment, if any, which the commissioner deems reasonably necessary to pay all claims, the costs and expenses of collecting the assessments and the costs and expense of the delinquency proceedings in full;

(iv) Any other information relative to the insurer's affairs or property the commissioner deems material.

26-28-130. Order and levy of assessment.

(a) Upon the filing and reading of the report and petition provided for in W.S. 26-28-129, the court, ex parte, may order the commissioner to assess all the insurer's members or subscribers who are subject to assessment, in an aggregate amount as the court finds reasonably necessary to pay all valid claims as may be timely filed and proved in the delinquency

proceedings, together with the costs and expenses of levying and collecting assessments and the costs and expenses of the delinquency proceedings in full. The order shall require that each member or subscriber be assessed for his proportion of the aggregate assessment, according to a reasonable classification of the members or subscribers and formula as the commissioner determines and the court approves.

(b) The court may order additional assessments upon the filings and reading of any amendment or supplement to the report and petition referred to in subsection (a) of this section, if the amendment or supplement is filed within three (3) years after the date of entry of the rehabilitation or liquidation order.

(c) The commissioner shall levy and assess members or subscribers in accordance with any order entered under this section.

(d) The total of all assessments against any member or subscriber with respect to any policy shall be for no greater amount than that specified in the member's or subscriber's policy and as limited under this code, except as to any policy which was issued at a rate of premium below the minimum rate lawfully permitted for the risk insured, in which case the assessment against any such policyholder shall be upon the basis of the minimum rate for that risk.

(e) No assessment shall be levied against any member or subscriber with respect to any nonassessable policy issued in accordance with this code.

26-28-131. Assessment prima facie correct; notice of amount of assessment; proceedings to enforce payment.

(a) Any assessment of a subscriber or member of an insurer which the commissioner makes pursuant to the court order fixing the aggregate amount of the assessment against all members or subscribers and approving the commissioner's classification and formula under W.S. 26-28-130(a) is prima facie correct.

(b) Each member or subscriber shall be notified of the amount of his assessment by written notice mailed to the member's or subscriber's address last of record with the insurer. Failure of the member or subscriber to receive the notice so mailed, within the time specified therein or at all, is not a defense in any proceeding to collect the assessment.

(c) If any member or subscriber fails to pay the assessment within the period specified in the notice, which period shall not be less than twenty (20) days from the date of mailing the notice, the commissioner may obtain an order in the delinquency proceedings requiring the member or subscriber to show cause at a time and place fixed by the court why judgment should not be entered against the member or subscriber for the amount of the assessment together with all costs. A copy of the order and a copy of the petition therefor shall be served upon the member or subscriber within the time and in the manner designated in the order.

(d) If the subscriber or member after service of a copy of the order and petition referred to in subsection (c) of this section is made upon him:

(i) Fails to appear at the time and place specified in the order, judgment shall be entered against him as prayed for in the petition; or

(ii) Appears in the manner and form required by law in response to the order, the court shall hear and determine the matter and enter a judgment in accordance with its decision.

(e) The commissioner may collect any assessment through any other lawful means.

CHAPTER 29 - FRATERNAL BENEFIT SOCIETIES

ARTICLE 1 - IN GENERAL

26-29-101. Repealed by Laws 1989, ch. 184, § 2.

26-29-102. Repealed by Laws 1989, ch. 184, § 2.

26-29-103. Repealed by Laws 1989, ch. 184, § 2.

26-29-104. Repealed by Laws 1989, ch. 184, § 2.

26-29-105. Repealed by Laws 1989, ch. 184, § 2.

26-29-106. Repealed by Laws 1989, ch. 184, § 2.

26-29-107. Repealed by Laws 1989, ch. 184, § 2.

26-29-108. Repealed by Laws 1989, ch. 184, § 2.

26-29-109. Repealed by Laws 1989, ch. 184, § 2.

26-29-110. Repealed by Laws 1989, ch. 184, § 2.

26-29-111. Repealed by Laws 1989, ch. 184, § 2.

26-29-112. Repealed by Laws 1989, ch. 184, § 2.

26-29-113. Repealed by Laws 1989, ch. 184, § 2.

26-29-114. Repealed by Laws 1989, ch. 184, § 2.

26-29-115. Repealed by Laws 1989, ch. 184, § 2.

26-29-116. Repealed by Laws 1989, ch. 184, § 2.

26-29-117. Repealed by Laws 1989, ch. 184, § 2.

26-29-118. Repealed by Laws 1989, ch. 184, § 2.

26-29-119. Repealed by Laws 1989, ch. 184, § 2.

26-29-120. Repealed by Laws 1989, ch. 184, § 2.

26-29-121. Repealed by Laws 1989, ch. 184, § 2.

26-29-122. Repealed by Laws 1989, ch. 184, § 2.

26-29-123. Repealed by Laws 1989, ch. 184, § 2.

26-29-124. Repealed by Laws 1989, ch. 184, § 2.

26-29-125. Repealed by Laws 1989, ch. 184, § 2.

26-29-126. Repealed by Laws 1989, ch. 184, § 2.

26-29-127. Repealed by Laws 1989, ch. 184, § 2.

26-29-128. Repealed by Laws 1989, ch. 184, § 2.

26-29-129. Repealed by Laws 1989, ch. 184, § 2.

26-29-130. Repealed by Laws 1989, ch. 184, § 2.

26-29-131. Repealed by Laws 1989, ch. 184, § 2.

26-29-132. Repealed by Laws 1989, ch. 184, § 2.

26-29-133. Repealed by Laws 1989, ch. 184, § 2.

26-29-134. Repealed by Laws 1989, ch. 184, § 2.

26-29-135. Repealed by Laws 1989, ch. 184, § 2.

26-29-136. Repealed by Laws 1989, ch. 184, § 2.

26-29-137. Repealed by Laws 1989, ch. 184, § 2.

26-29-138. Repealed by Laws 1989, ch. 184, § 2.

26-29-139. Repealed by Laws 1989, ch. 184, § 2.

26-29-140. Repealed by Laws 1989, ch. 184, § 2.

26-29-141. Repealed by Laws 1989, ch. 184, § 2.

26-29-142. Repealed by Laws 1989, ch. 184, § 2.

ARTICLE 2 - SOCIETIES

26-29-201. Fraternal benefit societies.

Any incorporated society, order or supreme lodge, without capital stock, including one exempted under W.S. 26-29-238(a)(ii), whether incorporated or not, conducted solely for the benefit of its members and their beneficiaries and not for profit, operated on a lodge system with ritualistic form of work, having a representative form of government, and which provides benefits in accordance with this chapter, is hereby declared to be a fraternal benefit society.

26-29-202. Lodge system.

(a) A society is operating on the lodge system if it has a supreme governing body and subordinate lodges into which members are elected, initiated or admitted in accordance with its laws, rules and ritual. Subordinate lodges shall be required by the laws of the society to hold regular meetings at least once in each month in furtherance of the purposes of the society.

(b) A society may, at its option, organize and operate lodges for children under the minimum age for adult membership. Membership and initiation in local lodges shall not be required

of those children, and they shall not have a voice or vote in the management of the society.

26-29-203. Representative form of government.

(a) A society has a representative form of government when:

(i) It has a supreme governing body constituted in one of the following ways:

(A) The supreme governing body is an assembly composed of delegates elected directly by the members or at intermediate assemblies or conventions of members or their representatives, together with other delegates as may be prescribed in the society's laws. A society may provide for election of delegates by mail. The elected delegates shall constitute a majority in number and shall not have less than a majority of the votes and shall have not less than two-thirds (2/3) of the vote and not less than the number of votes required to amend the society's laws. The assembly shall be elected and shall meet at least once every four (4) years and shall elect a board of directors to conduct the business of the society between meetings of the assembly. Vacancies on the board of directors between elections may be filled in the manner prescribed by the society's laws;

(B) The supreme governing body is a board composed of persons elected by the members, either directly or by their representatives in intermediate assemblies, and any other persons prescribed in the society's laws. A society may provide for election of the board by mail. Each term of a board member may not exceed four (4) years. Vacancies on the board between elections may be filled in the manner prescribed by the society's laws. Those persons elected to the board shall constitute a majority in number and not less than the number of votes required to amend the society's laws. A person filling the unexpired term of an elected board member shall be considered to be an elected member. The board shall meet at least quarterly to conduct the business of the society.

(ii) The officers of the society are elected either by the supreme governing body or by the board of directors;

(iii) Only benefit members are eligible for election to the supreme governing body, the board of directors or any intermediate assembly; and

(iv) Each voting member shall have one (1) vote, and no vote may be cast by proxy.

26-29-204. Definitions.

(a) As used in this chapter:

(i) "Benefit contract" means the agreement for provision of benefits authorized by W.S. 26-29-216, as that agreement is described in W.S. 26-29-219(a);

(ii) "Benefit member" means an adult member who is designated by the laws or rules of the society to be a benefit member under a benefit contract;

(iii) "Certificate" means the document issued as written evidence of the benefit contract;

(iv) "Laws" means the society's articles of incorporation, constitution and bylaws, however designated;

(v) "Lodge" means subordinate member units of the society, known as camps, courts, councils, branches or by any other designations;

(vi) "Premiums" means premiums, rates, dues or other required contributions by whatever name known, which are payable under the certificate;

(vii) "Rules" means all rules, regulations or resolutions adopted by the supreme governing body or board of directors which are intended to have general application to the members of the society;

(viii) "Society" means fraternal benefit society, unless otherwise indicated.

26-29-205. Purposes and powers.

(a) A society shall operate for the benefit of members and their beneficiaries by:

(i) Providing benefits as specified in W.S. 26-29-216; and

(ii) Operating for one (1) or more social, intellectual, educational, charitable, benevolent, moral, fraternal, patriotic or religious purposes for the benefit of its members, which may also be extended to others.

(b) The purposes of a society may be carried out directly by the society, or indirectly through subsidiary corporations or affiliated organizations.

(c) Every society shall have the power to adopt laws and rules for the government of the society, the admission of its members and the management of its affairs. It shall have the power to change, alter, add to or amend those laws and rules and shall have other powers as are necessary and incidental to carrying into effect the objects and purposes of the society.

26-29-206. Qualifications for membership.

(a) A society shall specify in its laws or rules:

(i) Eligibility standards for each and every class of membership, provided that if benefits are provided on the lives of children, the minimum age for adult membership shall be set at not less than age fifteen (15) and not greater than age twenty-one (21);

(ii) The process for admission to membership for each membership class; and

(iii) The rights and privileges of each membership class, provided that only benefit members shall have the right to vote on the management of the insurance affairs of the society.

(b) A society may also admit social members who shall have no voice or vote in the management of the insurance affairs of the society.

(c) Membership rights in the society are personal to the member and are not assignable.

26-29-207. Location of office; meetings; communications to members; grievance procedures.

(a) The principal office of any domestic society shall be located in this state. The meetings of its supreme governing body may be held in any state, district, province or territory

in which the society has at least five (5) subordinate lodges. All business transacted at those meetings shall be as valid in all respects as if the meetings were held in this state. The minutes of the proceedings of the supreme governing body and of the board of directors shall be in the English language.

(b) A society may provide in its laws for an official publication in which any notice, report or statement required by law to be given to members, including notice of election, may be published. These required reports, notices and statements shall be printed conspicuously in the publication. If the records of a society show that two (2) or more members have the same mailing address, an official publication mailed to one (1) member is deemed to be mailed to all members at the same address unless a member requests a separate copy.

(c) Not later than June 1 of each year, a synopsis of the society's annual statement providing an explanation of the facts concerning the condition of the society thereby disclosed shall be printed and mailed to each benefit member of the society or, in lieu thereof, the synopsis may be published in the society's official publication.

(d) A society may provide in its laws or rules for grievance or complaint procedures for members.

26-29-208. No personal liability.

(a) The officers and members of the supreme governing body or any subordinate body of a society shall not be personally liable for any benefits provided by a society.

(b) Any person may be indemnified and reimbursed by any society for expenses reasonably incurred by, and liabilities imposed upon, the person in connection with or arising out of any action, suit or proceeding, whether civil, criminal, administrative or investigative, or threat thereof, in which the person may be involved by reason of the fact that he is or was a director, officer, employee or agent of the society or of any firm, corporation or organization which he served in any capacity at the request of the society. Unless the person acted in good faith for a purpose the person reasonably believed to be in or not opposed to the best interests of the society and, in a criminal action or proceeding, in addition, had no reasonable cause to believe that his conduct was unlawful, a person shall not be so indemnified or reimbursed:

(i) In relation to any matter in an action, suit or proceeding as to which he shall finally be adjudged to be or have been guilty of breach of a duty as a director, officer, employee or agent of the society; or

(ii) In relation to any matter in an action, suit or proceeding, or threat thereof, which has been made the subject of a compromise settlement.

(c) The determination whether the conduct of a person met the standard required in order to justify indemnification and reimbursement in relation to any matter described in paragraph (b)(i) or (ii) of this section may only be made by the supreme governing body or board of directors by a majority vote of a quorum consisting of persons who were not parties to the action, suit or proceeding or by a court of competent jurisdiction. The termination of any action, suit or proceeding by judgment, order, settlement, conviction, or upon a plea of no contest, as to the person shall not in itself create a conclusive presumption that the person did not meet the standard of conduct required in order to justify indemnification and reimbursement. The foregoing right of indemnification and reimbursement shall not be exclusive of other rights to which the person may be entitled as a matter of law and shall inure to the benefit of his heirs, executors and administrators.

(d) A society may purchase and maintain insurance on behalf of any person who is or was a director, officer, employee or agent of the society, or who is or was serving at the request of the society as a director, officer, employee or agent of any other firm, corporation or organization against any liability asserted against the person and incurred by him in any official capacity or arising out of his status as enumerated above, whether or not the society would have the power to indemnify the person against the liability under this section.

26-29-209. Waiver.

The laws of the society may provide that no subordinate body or any of its subordinate officers or members shall have the power or authority to waive any of the provisions of the laws of the society. This provision shall be binding on the society and every member and beneficiary of a member.

26-29-210. Organization.

(a) Ten (10) or more citizens of the United States, a majority of whom are citizens of this state, who desire to form a fraternal benefit society, may make, sign and acknowledge before some officer competent to take acknowledgement of deeds, articles of incorporation, in which shall be stated:

(i) The proposed corporate name of the society, which shall not so closely resemble the name of any society or insurance company as to be misleading or confusing;

(ii) The purposes for which it is being formed and the mode in which its corporate powers are to be exercised. The purposes shall not include more liberal powers than are granted by this chapter;

(iii) The names and residences of the incorporators and the names, residences and official titles of all the officers, trustees, directors or other persons who are to have and exercise the general control of the management of the affairs and funds of the society for the first year or until the ensuing election at which all officers shall be elected by the supreme governing body, which election shall be held not later than one (1) year from the date of issuance of the permanent certificate of authority.

(b) The articles of incorporation, duly certified copies of the society's bylaws and rules, copies of all proposed forms of certificates, applications therefor, and circulars to be issued by the society and a bond conditioned upon the return to applicants of the advanced payments if the organization is not completed within one (1) year shall be filed with the commissioner, who may require further information as the commissioner deems necessary. The bond with sureties approved by the commissioner shall be in an amount, not less than three hundred thousand dollars ($300,000.00) nor more than one million five hundred thousand dollars ($1,500,000.00), as required by the commissioner. All documents filed are to be in the English language. If the purposes of the society conform to the requirements of this chapter and all provisions of the law have been complied with, the commissioner shall so certify, retain and file the articles of incorporation and furnish the incorporators a preliminary certificate of authority authorizing the society to solicit members as hereinafter provided.

(c) No preliminary certificate of authority granted under the provisions of this section shall be valid after one (1) year from its date or after an additional period, not exceeding one

(1) year, as may be authorized by the commissioner upon cause shown, unless the five hundred (500) applicants required in subsection (d) of this section have been secured and the organization has been completed as provided in this chapter. The articles of incorporation and all other proceedings thereunder shall become null and void in one (1) year from the date of the preliminary certificate of authority, or at the expiration of the extended period, unless the society has completed its organization and received a certificate of authority to do business as provided in this chapter.

(d) Upon receipt of a preliminary certificate of authority from the commissioner, the society may solicit members for the purpose of completing its organization, shall collect from each applicant the amount of not less than one (1) regular monthly premium in accordance with its table of rates, and shall issue to each applicant a receipt for the amount so collected. No society shall incur any liability other than for the return of the advance premium, nor issue any certificate, nor pay, allow or offer or promise to pay or allow, any benefit to any person until:

(i) Actual bona fide applications for benefits have been secured on not less than five hundred (500) applicants, and any necessary evidence of insurability has been furnished to and approved by the society;

(ii) At least ten (10) subordinate lodges have been established into which the five hundred (500) applicants have been admitted;

(iii) There has been submitted to the commissioner, under oath of the president or secretary, or corresponding officer of the society, a list of applicants, giving their names, addresses, date each was admitted, name and number of the subordinate lodge of which each applicant is a member, amount of benefits to be granted and premiums therefor; and

(iv) The commissioner receives a sworn statement of the treasurer, or corresponding officer of the society, that at least five hundred (500) applicants have each paid in cash at least one (1) regular monthly premium, which premiums in the aggregate shall amount to at least one hundred fifty thousand dollars ($150,000.00). The advance premiums shall be held in trust during the period of organization and if the society has not qualified for a certificate of authority within one (1) year, the premiums shall be returned to the applicants.

(e) The commissioner may make an examination and require further information as he deems advisable. Upon presentation of satisfactory evidence that the society has complied with all the provisions of law, the commissioner shall issue to the society a certificate of authority to that effect and that the society is authorized to transact business pursuant to the provisions of this chapter. The certificate of authority shall be prima facie evidence of the existence of the society at the date of the certificate. The commissioner shall cause a record of the certificate of authority to be made.

(f) Any incorporated society authorized to transact business in this state at the time this act becomes effective shall not be required to reincorporate.

26-29-211. Amendments to laws.

(a) A domestic society may amend its laws in accordance with the provisions thereof by action of its supreme governing body at any regular or special meeting thereof or, if its laws so provide, by referendum. The referendum may be held in accordance with the provisions of its laws by the vote of delegates or representatives of voting members or by the vote of local lodges. A society may provide for voting by mail. No amendment submitted for adoption by referendum shall be adopted unless, within six (6) months from the date of the submission thereof, a majority of the members voting shall have signified their consent to the amendment by one (1) of the methods specified in this chapter.

(b) No amendment to the laws of any domestic society shall take effect unless approved by the commissioner who shall approve the amendment if the commissioner finds that it has been properly adopted and is not inconsistent with any requirement of the laws of this state or with the character, objects and purposes of the society. Unless the commissioner expressly disapproves any amendment within sixty (60) days after the filing of the amendment, the amendment shall be considered approved. The approval or disapproval of the commissioner shall be in writing and mailed to the secretary or corresponding officer of the society at its principal office. In case the commissioner disapproves the amendment, the reasons therefor shall be stated in the written notice.

(c) Within ninety (90) days from the approval thereof by the commissioner, all amendments, or a synopsis thereof, shall

be furnished to all members of the society either by mail or by publication in full in the official publication of the society. The affidavit of any officer of the society or of anyone authorized by it to mail any amendments or synopsis thereof, stating facts which show that the amendments or a synopsis thereof have been addressed and mailed, shall be prima facie evidence that the amendments or synopsis thereof, have been furnished the addressee.

(d) Every foreign or alien society authorized to do business in this state shall file with the commissioner a certified copy of all amendments of, or additions to, its laws within ninety (90) days after the enactment of the amendments or additions to its laws.

(e) Printed copies of the laws as amended, certified by the secretary or corresponding officer of the society shall be prima facie evidence of the legal adoption thereof.

26-29-212. Institutions.

A society may create, maintain and operate, or may establish organizations to operate, not for profit institutions to further the purposes permitted by W.S. 26-29-205(a)(ii). The institutions may furnish services free or at a reasonable charge. Any real or personal property owned, held or leased by the society for this purpose shall be reported in every annual statement, but shall not be allowed as an admitted society asset. No society shall own or operate funeral homes or undertaking establishments.

26-29-213. Reinsurance.

(a) A domestic society may, by a reinsurance agreement, cede any individual risk or risks in whole or in part to an insurer, other than another fraternal benefit society, having the power to make reinsurance and authorized to do business in this state, or if not so authorized, one which is approved by the commissioner, but no domestic society may reinsure substantially all of its insurance in force without the written permission of the commissioner. It may take credit for the reserves on ceded risks to the extent reinsured, but no credit shall be allowed as an admitted asset or as a deduction from liability, to a ceding society for reinsurance made, ceded, renewed or otherwise becoming effective after the effective date of this act, unless the reinsurance is payable by the assuming insurer on the basis of the liability of the ceding society

under the contract or contracts reinsured without diminution because of the insolvency of the ceding society.

(b) Notwithstanding the limitation in subsection (a) of this section, a society may reinsure the risks of another society in a consolidation or merger approved by the commissioner under W.S. 26-29-214.

26-29-214. Consolidations and mergers.

(a) A domestic society may consolidate or merge with any other society by complying with the provisions of this section. It shall file with the commissioner:

(i) A certified copy of the written contract containing in full the terms and conditions of the consolidation or merger;

(ii) A sworn statement by the president and secretary or corresponding officers of each society showing the financial condition thereof on a date fixed by the commissioner but not earlier than December 31 next preceding the date of the contract;

(iii) A certificate of the officers, verified by their respective oaths, that the consolidation or merger has been approved by a two-thirds (2/3) vote of the supreme governing body of each society, the vote being conducted at a regular or special meeting of each supreme governing body, or, if the society's laws permit, by mail; and

(iv) Evidence that at least sixty (60) days prior to the action of the supreme governing body of each society, the text of the contract has been furnished to all members of each society either by mail or by publication in full in the official publication of each society.

(b) If the commissioner finds that the contract conforms with this section, that the financial statements are correct and that the consolidation or merger is just and equitable to the members of each society, the commissioner shall approve the contract and issue a certificate to that effect. Upon approval, the contract shall be in full force and effect unless any society which is a party to the contract is incorporated under the laws of any other state or territory. In that event the consolidation or merger shall not become effective unless and until it has been approved as provided by the laws of that state

or territory and a certificate of approval filed with the commissioner of this state or, if the laws of the state or territory contain no applicable provision, then the consolidation or merger shall not become effective unless and until it has been approved by the commissioner of that state or territory and certificate of approval filed with the commissioner of this state. In case the contract is not approved it shall be inoperative, and the fact of the submission and its contents shall not be disclosed by the commissioner.

(c) Upon consolidation or merger becoming effective as herein provided, all the rights, franchises and interests of the consolidated or merged societies in and to every species of property, real, personal or mixed, and things in action shall be vested in the society resulting from or remaining after the consolidation or merger without any other instrument, except that conveyances of real property may be evidenced by proper deeds, and the title to any real estate or interest therein, vested under the laws of this state in any of the societies consolidated or merged, shall not revert or be in any way impaired by reason of the consolidation or merger, but shall vest absolutely in the society resulting from or remaining after such consolidation or merger.

(d) The affidavit of any officer of the society or of anyone authorized by it to mail any notice or document, stating that the notice or document has been addressed and mailed, shall be prima facie evidence that the notice or document has been furnished the addressees.

26-29-215. Conversion of fraternal benefit society into mutual life insurance company.

Any domestic fraternal benefit society may be converted and licensed as a mutual life insurance company by compliance with all the requirements of the general insurance laws for mutual life insurance companies. A plan of conversion shall be prepared in writing by the board of directors setting forth in full the terms and conditions of conversion. The affirmative vote of two-thirds (2/3) of all members of the supreme governing body at a regular or special meeting is necessary for the approval of the plan. No conversion shall take effect unless and until approved by the commissioner who may give approval if the commissioner finds that the proposed change is in conformity with the requirements of law and not prejudicial to the certificate holders of the society.

26-29-216. Benefits.

(a) A society may provide the following contractual benefits in any form:

(i) Death benefits;

(ii) Endowment benefits;

(iii) Annuity benefits;

(iv) Temporary or permanent disability benefits;

(v) Hospital, medical or nursing benefits;

(vi) Monument or tombstone benefits to the memory of deceased members; and

(vii) Other benefits as authorized for life insurers and which are not inconsistent with this chapter.

(b) A society shall specify in its rules those persons who may be issued, or covered by, the contractual benefits in subsection (a) of this section, consistent with providing benefits to members and their dependents. A society may provide benefits on the lives of children under the minimum age for adult membership upon application of an adult person.

26-29-217. Beneficiaries.

(a) The owner of a benefit contract shall have the right at all times to change the beneficiary or beneficiaries in accordance with the laws or rules of the society unless the owner waives this right by specifically requesting in writing that the beneficiary designation be irrevocable. A society may, through its laws or rules, limit the scope of beneficiary designations and shall provide that no revocable beneficiary shall have or obtain any vested interest in the proceeds of any certificate until the certificate has become due and payable in conformity with the provisions of the benefit contract.

(b) A society may provide for the payment of funeral benefits to the extent of the portion of any payment under a certificate as might reasonably appear to be due to any person equitably entitled thereto by reason of having incurred expense occasioned by the burial of the member, provided the payment shall not exceed five hundred dollars ($500.00).

(c) If, at the death of any member, there is no lawful beneficiary to whom the insurance benefits are payable, the amount of the benefits, except to the extent that funeral benefits may be paid as provided in subsection (b) of this section, shall be payable to the personal representative of the deceased insured, provided that if the owner of the certificate is other than the insured, the proceeds shall be payable to the owner.

26-29-218. Benefits not attachable.

No money or other benefit, charity, relief or aid to be paid, provided or rendered by any society, shall be liable to attachment, garnishment or other process, or to be seized, taken, appropriated or applied by any legal or equitable process or operation of law to pay any debt or liability of a member or beneficiary, or any other person who may have a right thereunder, either before or after payment by the society.

26-29-219. Benefit contract.

(a) Every society authorized to do business in this state shall issue to each owner of a benefit contract a certificate specifying the amount of benefits provided thereby. The certificate, together with any riders or endorsements attached thereto, the laws of the society, the application for membership, the application for insurance and declaration of insurability, if any, signed by the applicant, and all amendments thereto, shall constitute the benefit contract, as of the date of issuance, between the society and the owner, and the certificate shall so state. A copy of the application for insurance and declaration of insurability, if any, shall be endorsed upon or attached to the certificate. All statements on the application shall be representations and not warranties. Any waiver of this provision shall be void.

(b) Any changes, additions or amendments to the laws of the society duly made or enacted subsequent to the issuance of the certificate, shall bind the owner and the beneficiaries, and shall govern and control the benefit contract in all respects the same as though the changes, additions or amendments had been made prior to and were in force at the time of the application for insurance, except that no change, addition or amendments shall destroy or diminish benefits which the society contracted to give the owner as of the date of issuance.

(c) Any person upon whose life a benefit contract is issued prior to attaining the age of majority shall be bound by the terms of the application and certificate and by all the laws and rules of the society to the same extent as though the age of majority had been attained at the time of application.

(d) A society shall provide in its laws that if its reserves as to all or any class of certificates become impaired its board of directors or corresponding body may require that there shall be paid by the owner to the society the amount of the owner's equitable proportion of the deficiency as ascertained by its board, and that if the payment is not made:

(i) It shall stand as an indebtedness against the certificate and draw interest not to exceed the rate specified for certificate loans under the certificates; or

(ii) In lieu of or in combination with paragraph (i) of this subsection, the owner may accept a proportionate reduction in benefits under the certificate.

(e) The society may specify the manner of the election and which alternative is to be presumed if no election is made pursuant to subsection (d) of this section.

(f) Copies of any of the documents specified in this section, certified by the secretary or corresponding officer of the society, shall be received in evidence of the terms and conditions thereof.

(g) No certificate shall be delivered or issued for delivery in this state unless a copy of the form has been filed with and approved by the commissioner in the manner provided for like policies issued by life insurers in this state. Every life, accident, health or disability insurance certificate and every annuity certificate issued on or after one (1) year from the effective date of this act shall meet the standard contract provision requirements not inconsistent with this chapter for like policies issued by life insurers in this state, except that a society may provide for a grace period for payment of premiums of one (1) full month in its certificates. The certificate shall also contain a provision stating the amount of premiums which are payable under the certificate and a provision reciting or setting forth the substance of any sections of the society's laws or rules in force at the time of issuance of the certificate which, if violated, will result in the termination or reduction of benefits payable under the certificate. If the

laws of the society provide for expulsion or suspension of a member, the certificate shall also contain a provision that any member so expelled or suspended, except for nonpayment of a premium or within the contestable period for material misrepresentation in the application for membership or insurance, shall have the privilege of maintaining the certificate in force by continuing payment of the required premium.

(h) Benefit contracts issued on the lives of persons below the society's minimum age for adult membership may provide for transfer of control of ownership to the insured at an age specified in the certificate. A society may require approval of an application for membership in order to effect this transfer, and may provide in all other respects for the regulation, government and control of the certificates and all rights, obligations and liabilities incident thereto and connected therewith. Ownership rights prior to the transfer shall be specified in the certificate.

(j) A society may specify the terms and conditions on which benefit contracts may be assigned.

26-29-220. Nonforfeiture benefits; cash surrender values; certificate loans and other options.

(a) For certificates issued prior to one (1) year after the effective date of this act, the value of every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan or other option granted shall comply with the provisions of law applicable on December 31, 1989.

(b) For certificates issued on or after one (1) year from the effective date of this act for which reserves are computed on the Commissioner's 1941 Standard Ordinary Mortality Table, the Commissioner's 1941 Standard Industrial Table or the Commissioner's 1958 Standard Ordinary Mortality Table, or the Commissioner's 1980 Standard Mortality Table, or any more recent table made applicable to life insurers, every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan or other option granted shall not be less than the corresponding amount ascertained in accordance with the laws of this state applicable to life insurers issuing policies containing like benefits based upon such tables.

26-29-221. Investments.

A society shall invest its funds only in investments authorized by Wyoming statutes for the investment of assets of life insurers and subject to the limitations thereon. Any foreign or alien society permitted or seeking to do business in this state which invests its funds in accordance with the laws of the state, district, territory, country or province in which it is incorporated, shall be held to meet the requirements of this section for the investment of funds.

26-29-222. Funds.

(a) All assets shall be held, invested and disbursed for the use and benefit of the society and no member or beneficiary shall have or acquire individual rights therein or become entitled to any apportionment on the surrender of any part thereof, except as provided in the benefit contract.

(b) A society may create, maintain, invest, disburse and apply any special fund or funds necessary to carry out any purpose permitted by laws of such society.

(c) A society may, pursuant to resolution of its supreme governing body, establish and operate one (1) or more separate accounts and issue contracts on a variable basis, subject to the provisions of law regulating life insurers establishing such accounts and issuing such contracts. To the extent the society deems it necessary in order to comply with any applicable federal or state laws, or any rules issued thereunder, the society may adopt special procedures for the conduct of the business and affairs of a separate account, may, for persons having beneficial interests therein, provide special voting and other rights, including without limitation special rights and procedures relating to investment policy, investment advisory services, selection of certified public accountants, and selection of a committee to manage the business and affairs of the account, and may issue contracts on a variable basis to which W.S. 26-29-219(b) and (d) shall not apply.

26-29-223. Exemptions.

Except as otherwise provided in this chapter, societies shall be governed by this chapter and shall be exempt from all other provisions of the general insurance laws of this state unless they be expressly designated therein, or unless it is specifically made applicable by this chapter.

26-29-224. Exemption from taxation.

Every society organized or licensed under this chapter is hereby declared to be a charitable and benevolent institution, and all of its funds shall be exempt from all and every state, county, district, municipal and school tax other than taxes on real estate.

26-29-225. Valuation.

(a) Standards of valuation for certificates issued prior to one (1) year after the effective date of this act shall be those provided by the laws applicable on December 31, 1989.

(b) The minimum standards of valuation for certificates issued on or after one (1) year from the effective date of this act shall be based on the following tables:

(i) For certificates of life insurance, the Commissioner's 1941 Standard Ordinary Mortality Table, the Commissioner's 1941 Standard Industrial Mortality Table, the Commissioner's 1958 Standard Ordinary Mortality Table, the Commissioner's 1980 Standard Ordinary Mortality Table or any more recent table made applicable to life insurers;

(ii) For annuity and pure endowment certificates, for total and permanent disability benefits, for accidental death benefits and for noncancelable accident and health benefits, tables authorized for use by life insurers in this state.

(c) All of the standards provided in subsection (b) of this section shall be under valuation methods and standards, including interest assumptions, in accordance with the laws of this state applicable to life insurers issuing policies containing like benefits.

(d) The commissioner may, in his discretion, accept other standards for valuation if the commissioner finds that the reserves produced thereby will not be less in the aggregate than reserves computed in accordance with the minimum valuation standard prescribed in this section. The commissioner may, in his discretion, vary the standards of mortality applicable to all benefit contracts on substandard lives or other extrahazardous lives by any society authorized to do business in this state.

(e) Any society, with the consent of the commissioner of the state of domicile of the society and under conditions, if

any, which the commissioner may impose, may establish and maintain reserves on its certificates in excess of the reserves required thereunder, but the contractual rights of any benefit member shall not be affected thereby.

26-29-226. Reports.

(a) Every society transacting business in this state shall annually, on or before March 1, unless for cause shown the time has been extended by the commissioner, file with the commissioner a true statement of its financial condition, transactions and affairs for the preceding calendar year and pay a two hundred fifty dollar ($250.00) filing fee. The statement shall be in general form and context as approved by the National Association of Insurance Commissioners for fraternal benefit societies and as supplemented by additional information required by the commissioner. The statement shall be completed pursuant to the most recent National Association of Insurance Commissioners' accounting practices and procedures manual. The commissioner may accept, for any society not domiciled in this state which is required to file any statement under this subsection, an electronic filing with the National Association of Insurance Commissioners meeting the requirements of this subsection as a filing with the commissioner.

(b) As part of the annual statement herein required, each society shall, on or before March 1, file with the commissioner a valuation of its certificates in force on the immediately preceding December 31, provided the commissioner may, in his discretion for cause shown, extend the time for filing the valuation for not more than two (2) calendar months. The valuation shall be done in accordance with the standards specified in W.S. 26-29-225. The valuation and underlying data shall be certified by a qualified actuary or, at the expense of the society, verified by the actuary of the department of insurance of the state of domicile of the society.

(c) A society neglecting to file the annual statement in the form and within the time provided by this section shall forfeit one hundred dollars ($100.00) for each day during which such neglect continues, and upon notice by the commissioner to that effect, its authority to do business in this state shall cease while the default continues.

(d) Chapter 3, article 3 of this code shall apply to every society transacting business in this state except to the extent that the commissioner determines that the nature of fraternal

benefit societies render that chapter and article, or any portion thereof, clearly inappropriate.

26-29-227. Annual license.

Societies which are now authorized to transact business in this state may continue business until February 28, 1990. The authority of those societies and all societies licensed under this chapter, may thereafter be renewed annually, but in all cases to terminate on the last day of the succeeding February. However, a license so issued shall continue in full force and effect until the new license is issued or specifically refused. For each license or renewal the society shall pay the commissioner two hundred fifty dollars ($250.00). A duly certified copy or duplicate of the license shall be prima facie evidence that the licensee is a fraternal benefit society within the meaning of this chapter.

26-29-228. Examination of societies.

(a) The commissioner, or his designee, may examine any domestic, foreign or alien society transacting or applying for admission to transact business in this state in the same manner as authorized for examination of domestic, foreign or alien insurers. Requirements of notice and an opportunity to respond before findings are made public as provided in the laws regulating insurers shall also be applicable to the examination of societies.

(b) The expense of each examination and of each valuation, including compensation and actual expense of examiners, shall be paid by the society examined or whose certificates are valued, upon statements furnished by the commissioner.

26-29-229. Foreign or alien society; admission.

(a) No foreign or alien society shall transact business in this state without a license issued by the commissioner. Any foreign or alien society desiring admission to this state shall comply substantially with the requirements and limitations of this chapter applicable to domestic societies and may be licensed to transact business in this state upon filing with the commissioner:

(i) A duly certified copy of its articles of incorporation;

(ii) A copy of its bylaws, certified by its secretary or corresponding officer;

(iii) A power of attorney to the commissioner as prescribed in W.S. 26-29-235;

(iv) A statement of its business under oath of its president and secretary or corresponding officers in a form prescribed by the commissioner, duly verified by an examination made by the supervising insurance official of its home state or other state, territory, province or country, satisfactory to the commissioner of this state;

(v) Certification from the proper official of its home state, territory, province or country that the society is legally incorporated and licensed to transact business therein;

(vi) Copies of its certificate forms;

(vii) A written statement showing that its assets are invested in accordance with the provisions of this chapter; and

(viii) Other information as the commissioner deems necessary.

(b) Any foreign or alien society desiring admission to the state shall have the qualifications required of domestic societies organized under this chapter.

26-29-230. Injunction; liquidation; receivership of domestic society.

(a) The commissioner shall at once provide written notification to a society when the commissioner upon investigation finds that a domestic society:

(i) Has exceeded its powers;

(ii) Has failed to comply with any provision of this chapter;

(iii) Is not fulfilling its contracts in good faith;

(iv) Has a membership of less than four hundred (400) after an existence of one (1) year or more; or

(v) Is conducting business fraudulently or in a manner hazardous to its members, creditors, the public or the business.

(b) The commissioner shall notify the society of any deficiency specified in subsection (a) of this section and state in writing the reasons why he believes the deficiency exists. The commissioner shall at once issue a written notice to the society requiring that the deficiency be corrected. After the notice the society has thirty (30) days in which to comply with the commissioner's request for correction, and if the society fails to comply, the commissioner shall notify the society of its findings of noncompliance and require the society to show cause on a date named why it should not be enjoined from carrying on any business until the violation complained of shall have been corrected, or why an action in quo warranto should not be commenced against the society.

(c) If on that date the society does not present good and sufficient reasons why it should not be so enjoined or why such action should not be commenced, the commissioner may present the facts relating thereto to the attorney general who shall, if he deems the circumstances warrant, commence an action to enjoin the society from transacting business or in quo warranto.

(d) If after a full hearing it appears that the society should be enjoined from transacting business or liquidated or a receiver appointed, the court shall enter the necessary order. No society enjoined under this subsection may do business until:

(i) The commissioner finds that the violation complained of has been corrected;

(ii) The costs of the action have been paid by the society if the court finds that the society was in default as charged;

(iii) The court has dissolved its injunction; and

(iv) The commissioner has reinstated the certificate of authority.

(e) If the court orders the society liquidated, it shall be enjoined from carrying on any further business, whereupon the receiver of the society shall proceed at once to take possession of the books, papers, money and other assets of the society and, under the direction of the court, proceed forthwith to close the

affairs of the society and to distribute its funds to those entitled thereto.

(f) No action under this section shall be recognized in any court of this state unless brought by the attorney general upon request of the commissioner. Whenever a receiver is to be appointed for a domestic society, the court shall appoint the commissioner as receiver.

(g) The provisions of this section relating to hearing by the commissioner, action by the attorney general at the request of the commissioner, hearing by the court, injunction and receivership shall be applicable to a society which shall voluntarily determine to discontinue business.

26-29-231. Suspension, revocation or refusal of license of society.

(a) The commissioner shall at once provide written notification to a society when the commissioner upon investigation finds that a society transacting or applying to transact business in this state:

(i) Has exceeded its powers;

(ii) Has failed to comply with any of the provisions of this chapter;

(iii) Has become insolvent;

(iv) Is not fulfilling its contracts in good faith; or

(v) Is conducting its business fraudulently or in a manner hazardous to its members or creditors or the public.

(b) The commissioner shall notify the society of the deficiency as provided in subsection (a) of this section and state in writing the reasons why he believes the deficiency exists. The commissioner shall at once issue a written notice to the society requiring that the deficiency be corrected. After the notice the society has thirty (30) days in which to comply with the commissioner's request for correction, and if the society fails to comply, the commissioner shall notify the society of findings of noncompliance and require the society to show cause on a date named why its license should not be suspended, revoked or refused. If on that date the society does

not present a good and sufficient reason why its authority to do business in this state should not be suspended, revoked or refused, the commissioner may suspend or refuse the license of the society to do business in this state until satisfactory evidence is furnished to the commissioner that the suspension or refusal should be withdrawn or the commissioner may revoke the authority of the society to do business in this state.

(c) Nothing contained in this section shall be taken or construed as preventing any society from continuing in good faith all contracts made in this state during the time such society was legally authorized to transact business herein.

(d) In making the finding allowed by subsection (a) of this section, the commissioner may consider the factors specified in W.S. 26-3-116(c) and 26-3-132(a) and, upon finding a deficiency, may issue an order consistent with W.S. 26-3-132(b) and pursuant to the procedure established in W.S. 26-3-132(c).

26-29-232. Injunction.

No application or petition for injunction against any domestic, foreign or alien society, or lodge thereof, shall be recognized in any court of this state unless made by the attorney general upon request of the commissioner.

26-29-233. Licensing of agents.

(a) Agents of societies shall be licensed in accordance with the provisions of the laws regulating the licensing, revocation, suspension or termination of license of resident and nonresident agents, provided that no examination shall be required of any agent licensed prior to the effective date of this act.

(b) No examination or license shall be required of any regular salaried officer, employee or member of a licensed society who devotes substantially all of his services to activities other than the solicitation of fraternal insurance contracts from the public, and who receives for the solicitation of those contracts no commission or other compensation directly dependent upon the amount of business obtained.

(c) Any agent or representative of a society who devotes, or intends to devote, less than fifty percent (50%) of his time to solicitation and procurement of insurance contracts for the

society is exempt from the requirements of subsection (a) of this section. Any person who in the immediately preceding calendar year solicited and procured life insurance contracts on behalf of any society in an amount of insurance in excess of fifty thousand dollars ($50,000.00), or, in the case of any other kinds of insurance which the society writes, on the persons of more than ten (10) individuals and who received or will receive a commission or other compensation therefor, is presumed to be devoting or intending to devote, fifty percent (50%) of his time to the solicitation or procurement of insurance contracts for the society. The person shall report sales of insurance under this subsection as required by the commissioner.

26-29-234. Unfair methods of competition; unfair and deceptive acts and practices.

Every society authorized to do business in this state is subject to chapter 13 of title 26, the Unfair Trade Practices Act, provided, that nothing in that act shall be construed as applying to or affecting the right of any society to determine its eligibility requirements for membership, or be construed as applying to or affecting the offering of benefits exclusively to members or person eligible for membership in the society by a subsidiary corporation or affiliated organization of the society.

26-29-235. Service of process.

(a) Every society authorized to do business in this state shall appoint in writing the commissioner to be its true and lawful attorney upon whom all lawful process in any action or proceeding against it shall be served, and shall agree in the writing that any lawful process against it which is served on the commissioner shall be of the same legal force and validity as if served upon the society, and that the authority shall continue in force so long as any liability remains outstanding in this state. Copies of the appointment, certified by the commissioner, shall be deemed sufficient evidence thereof and shall be admitted in evidence with the same force and effect as the original.

(b) Service shall only be made upon the commissioner, or if absent, upon the person in charge of the commissioner's office. It shall be made in duplicate and shall constitute sufficient service upon the society. When legal process against a society is served upon the commissioner, the commissioner

shall forthwith forward one (1) of the duplicate copies by registered mail, prepaid, directed to the secretary or corresponding officer. No service shall require a society to file its answer, pleading or defense in less than thirty (30) days from the date of mailing the copy of the service to a society. Legal process shall not be served upon a society except in the manner herein provided. At the time of serving any process upon the commissioner, the plaintiff or complainant in the action shall pay to the commissioner a fee as provided in W.S. 26-4-101.

26-29-236. Review.

All decisions and findings of the commissioner made under the provisions of this chapter shall be subject to review by proper proceedings in any court of competent jurisdiction in this state.

26-29-237. Penalties.

(a) Any person who willfully makes a false or fraudulent statement in or relating to an application for membership or for the purpose of obtaining money from or a benefit in any society is guilty of a misdemeanor punishable by a fine of not less than one hundred dollars ($100.00) or more than five hundred dollars ($500.00), or imprisonment for not less than thirty (30) days or more than one (1) year, or both.

(b) Any person who willfully makes a false or fraudulent statement in any verified report or declaration under oath required or authorized by this chapter, or of any material fact or thing contained in a sworn statement concerning the death or disability of a member for that purpose of procuring payment of a benefit named in the certificate, is guilty of perjury punishable as provided by law.

(c) Any person who solicits membership for, or in any manner assists in procuring membership in, any society not licensed to do business in this state, upon conviction, is guilty of a misdemeanor punishable by a fine of not less than fifty dollars ($50.00) or more than two hundred dollars ($200.00).

(d) Any person guilty of a willful violation of, or neglect or refusal to comply with this chapter for which a penalty is not otherwise prescribed, upon conviction is subject to the penalties provided by W.S. 26-1-107.

26-29-238. Exemption of certain societies.

(a) Nothing contained in this chapter shall be so construed as to affect or apply to:

(i) Grand or subordinate lodges of societies, orders or associations now doing business in this state which provide benefits exclusively through local or subordinate lodges;

(ii) Orders, societies or associations which admit to membership only persons engaged in one (1) or more crafts or hazardous occupations, in the same or similar lines of business, insuring only their own members and their families, and the ladies' societies or ladies' auxiliaries to such orders, societies or associations;

(iii) Domestic societies which limit their membership to employees of a particular city or town, designated firm, business house or corporation which provide for a death benefit of not more than four hundred dollars ($400.00) or disability benefits of not more than three hundred fifty dollars ($350.00) to any person in any one (1) year, or both; or

(iv) Domestic societies or associations of a purely religious, charitable or benevolent description, which provide for a death benefit of not more than four hundred dollars ($400.00) or for disability benefits of not more than three hundred fifty dollars ($350.00) to any one (1) person in any one (1) year, or both.

(b) Any society or association described in paragraph (a)(iii) or (iv) of this section which provides for death or disability benefits for which benefit certificates are issued, and any society or association included in paragraph (a)(iv) of this section which has more than one thousand (1,000) members, shall not be exempted from the provisions of this chapter but shall comply with all requirements thereof.

(c) No society which, by the provisions of this section, is exempt from the requirements of this chapter, except any society described in paragraph (a)(ii) of this section, shall give or allow, or promise to give or allow to any person any compensation for procuring new members.

(d) Every society which provides for benefits in case of death or disability resulting solely from accident, and which

does not obligate itself to pay natural death or sick benefits shall have all of the privileges and be subject to all the applicable provisions and regulations of this chapter except that the provisions relating to medical examination, valuations of benefit certificates, and incontestability, shall not apply to that society.

(e) The commissioner may require from any society or association, by examination or otherwise, such information as will enable the commissioner to determine whether the society or association is exempt from the provisions of this chapter.

(f) Societies, exempted under this section, shall also be exempt from all other provisions of the general insurance laws of this state.

26-29-239. Application of Wyoming Insurance Corporate Governance Annual Disclosure Act.

The Wyoming Insurance Corporate Governance Annual Disclosure Act, W.S. 26-54-101 through 26-54-108, shall apply to domestic fraternal benefit societies regulated under this chapter.

CHAPTER 30 - UNCLAIMED FUNDS OF INSURANCE COMPANY

26-30-101. Repealed by Laws 1993, ch. 213., § 3.

26-30-102. Repealed by Laws 1993, ch. 213., § 3.

26-30-103. Repealed by Laws 1993, ch. 213., § 3.

26-30-104. Repealed by Laws 1993, ch. 213., § 3.

CHAPTER 31 - WYOMING INSURANCE GUARANTY ASSOCIATION ACT

26-31-101. Short title.

This chapter is known and may be cited as the "Wyoming Insurance Guaranty Association Act".

26-31-102. Applicability.

This chapter applies to all kinds of direct insurance, except life, title, surety, disability, credit, mortgage guaranty and ocean marine insurance.

26-31-103. Definitions.

(a) As used in this chapter:

(i) "Association" means the Wyoming Insurance Guaranty Association created under W.S. 26-31-104;

(ii) "Covered claim" means an unpaid claim which arises out of and is within the coverage and does not exceed the applicable limits of an insurance policy to which this chapter applies issued by an insurer, if the insurer is an insolvent insurer and the claimant or insured is a resident of this state at the time of the insured event or the property from which the claim arises is permanently located in this state, but "covered claim" does not include:

(A) Any amount due any reinsurer, insurer, insurance pool or underwriting association as subrogation recoveries or otherwise;

(B) Repealed by Laws 1990, ch. 96, § 3.

(C) Any amount exceeding the applicable limits of liability provided by an insurance policy to which this chapter applies;

(D) Supplementary payment obligations, including but not limited to adjustment fees and expenses, attorney fees and expenses, court costs, interest and bond premiums;

(E) Any amount awarded as punitive or exemplary damages, unless those damages are specifically named as covered risks in the policy under which coverage is provided; or

(F) Any amount claimed for incurred but not reported damages.

(iii) "Insolvent insurer" means an insurer:

(A) Licensed to transact insurance in this state either at the time the policy is issued or when the insured event occurs;

(B) Against which a final order of liquidation, with a finding of insolvency, is entered by a court of competent jurisdiction in the insurer's state of domicile and;

(C) With respect to which no order, decree or finding relating to the insurer's solvency, has been issued by a court of competent jurisdiction or by the insurance commissioner, prior to February 27, 1971.

(iv) "Member insurer" means any person who:

(A) Writes any kind of insurance to which this chapter applies, including the exchange of reciprocal or interinsurance contracts; and

(B) Is licensed to transact insurance in this state.

(v) "Net direct written premiums" means direct gross premiums written in this state on insurance policies to which this chapter applies, less return premiums thereon and dividends paid or credited to policyholders on that direct business but does not include premiums on contracts between insurers or reinsurers;

(vi) "Person" means any individual, corporation, partnership, association or voluntary organization.

26-31-104. Association created; members; operation and exercise of powers.

(a) There is created a nonprofit unincorporated legal entity to be known as the Wyoming Insurance Guaranty Association.

(b) All member insurers as defined in this chapter are members of the association as a condition of their authority to transact insurance in this state.

(c) The association shall:

(i) Perform its functions under a plan of operation established and approved under W.S. 26-31-108; and

(ii) Exercise its powers through a board of directors established under W.S. 26-31-105.

26-31-105. Board of directors.

(a) The board of directors of the association shall consist of not less than five (5) nor more than nine (9) persons

serving terms as established in the plan of operation. The board members shall be selected by member insurers subject to the commissioner's approval. Vacancies on the board shall be filled for the remaining period of the term in the same manner as initial appointments.

(b) In approving selections to the board, the commissioner shall consider among other things whether all member insurers are fairly represented.

(c) Board members may be reimbursed from the association's assets for expenses they incur as board members.

26-31-106. Duties and powers of association.

(a) Except as provided in subsection (c) of this section, the association shall:

(i) Be obligated to pay covered claims:

(A) Existing prior to the determination of insolvency and arising within thirty (30) days after the determination of insolvency; or

(B) Arising before the policy expiration date if the claims arise:

(I) Less than thirty (30) days after the determination of insolvency; or

(II) Before the insured replaces the policy or causes its cancellation, which replacement or cancellation occurs within thirty (30) days of the determination of insolvency.

(ii) Be deemed the insurer to the extent of its obligation of the covered claims and to that extent has all rights, duties and obligations of the insolvent insurer as if the insurer were not insolvent;

(iii) As provided in W.S. 26-31-107 assess insurers amounts necessary to pay the association's obligations under paragraph (i) of this subsection and subsection (c) of this section subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, the cost of examinations under W.S. 26-31-112 and any other expenses authorized by this chapter;

(iv) Investigate claims brought against the association and adjust, compromise, settle and pay covered claims to the extent of the association's obligation and deny all other claims;

(v) Notify any persons as the commissioner directs under W.S. 26-31-109(a)(iii);

(vi) Handle claims through its employees or through one (1) or more insurers or other persons designated as servicing facilities, whose voluntary accepted designation is subject to the commissioner's approval;

(vii) Reimburse each servicing facility for association obligations it pays and for expenses incurred while handling association claims; and

(viii) Pay any other association expenses authorized by this chapter.

(b) The association may:

(i) Appear in, defend and appeal any action on a covered claim or on a claim brought against the association;

(ii) Employ or retain any persons necessary to handle claims and perform other association duties;

(iii) Borrow funds necessary to effect the purposes of this chapter in accord with the plan of operation;

(iv) Sue or be sued;

(v) Negotiate and become a party to contracts necessary to carry out the purpose of this chapter;

(vi) Review settlements, releases and judgments to which the insolvent insurer or its insureds were parties to determine the extent to which the settlements, releases and judgments may be properly contested;

(vii) Refund to the member insurers in proportion to the contribution of each member insurer, that amount by which the association's assets exceed its liabilities as the board of directors determines;

(viii) Perform any other acts necessary to carry out the purpose of this chapter.

(c) Notwithstanding subsection (a) of this section, the association:

(i) Shall pay the full amount of a covered claim for benefits under worker's compensation coverage;

(ii) Shall pay not more than seven thousand five hundred dollars ($7,500.00) per policy for a covered claim for return of each unearned premium;

(iii) Shall pay not more than three hundred thousand dollars ($300,000.00) for each covered claim, other than worker's compensation and return of unearned premium claims;

(iv) Is not obligated to pay a claimant an amount in excess of the obligation of the insolvent insurer under the policy or coverage from which the claim arises.

(d) Payment of covered claims by the association pursuant to this chapter shall be made to the claimant or insured and not to the insurer or an agent of the insurer on behalf of the insured.

26-31-107. Member insurer assessments.

(a) The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the preceding calendar year bears to the net direct written premiums of all member insurers for the preceding calendar year. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. No member insurer shall be assessed in any year an amount greater than one percent (1%) of that member insurer's net direct written premiums for the preceding calendar year. If the maximum assessment, together with the other association assets, do not provide in any one (1) year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portions shall be paid as soon thereafter as funds become available.

(b) The association may exempt or defer, in whole or in part, the assessment of any member insurer if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts

required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance. During the period of deferment, no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when the payment will not reduce capital or surplus below required minimums. The payments shall be refunded to those companies receiving larger assessments because of the deferment, or, if the company elects, credited against future assessments.

26-31-108. Plan of operation.

(a) The association shall submit to the commissioner a plan of operation and any amendments thereto necessary or suitable to assure the association's fair, reasonable and equitable administration. The plan of operation and any amendments thereto are effective upon the commissioner's written approval.

(b) If the association fails to submit a suitable plan of operation or if at any time the association fails to submit suitable amendments to the plan, the commissioner, after notice and hearing, shall promulgate any reasonable rules necessary or advisable to carry out the provisions of this chapter. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

(c) All member insurers shall comply with the plan of operation.

(d) The plan of operation shall:

(i) Establish procedures for:

(A) The association to perform its powers and duties;

(B) Handling association assets;

(C) The amount and method of reimbursing members of the board of directors;

(D) Filing claims with the association and determining acceptable forms of proof of covered claims. Notice of claims to the receiver or liquidator of the insolvent insurer shall be deemed notice to the association or its agent and a list of claims shall be periodically submitted to the

association or similar organization in another state by the receiver or liquidator;

(E) Records to be kept of all financial transactions of the association, its agents and the board of directors;

(F) Any member insurer aggrieved by any final association action or decision to appeal to the commissioner within thirty (30) days after the action or decision;

(G) Submitting selections for the board of directors to the commissioner.

(ii) Establish regular places and times for meetings of the board of directors;

(iii) Contain additional provisions necessary or proper for executing the association's powers and duties.

(e) The plan of operation may provide for the delegation of any association powers and duties, except those under W.S. 26-31-106(a)(iii) and (b)(iii), to a corporation, association or other organization which performs or will perform functions similar to those of this association, or its equivalent, in two (2) or more states. The corporation, association or organization shall be reimbursed as a servicing facility would be reimbursed and shall be paid for its performance of any other association functions. A delegation under this subsection is effective 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 chapter.

26-31-109. Duties and powers of commissioner; judicial review.

(a) The commissioner shall:

(i) Notify the association of an insolvent insurer's existence not later than three (3) days after he receives notice of the insolvency determination;

(ii) Upon request of the board of directors, provide the association with a statement of the net direct written premiums of each member insurer;

(iii) Require that the association notify the insolvent insurer's insureds and any other interested parties of the insolvency determination and of their rights under this chapter. The notification shall be by mail at their last known address, if available, but if sufficient information for notification by mail is not available, notice by publication in a newspaper of general circulation is sufficient.

(b) The commissioner may:

(i) After notice and hearing:

(A) Suspend or revoke 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; or

(B) Levy a fine on any member insurer which fails to pay an assessment when due, which fine shall not exceed five percent (5%) of the unpaid assessment per month, except that no fine shall be less than one hundred dollars ($100.00) per month.

(ii) Revoke the designation of any servicing facility if he finds claims are being handled unsatisfactorily;

(iii) Require each agent of the insolvent insurer to give prompt written notice by first class mail, at the insured's last known address, to each insured of the insolvent insurer for whom he was agent of record.

(c) Any final action or order of the commissioner under this chapter is subject to review in accordance with W.S. 26-2-129.

26-31-110. Insured's rights and liabilities; settlements binding on receiver or liquidator; priority of claims; statements to be filed with receiver or liquidator.

(a) Any person recovering under this chapter assigns his rights under the policy to the association to the extent of his recovery from the association. Any insured or claimant seeking the protection of this chapter shall cooperate with the association to the same extent as that person would have been required to cooperate with the insolvent insurer. The association has no cause of action against the insolvent insurer's insured for any sums it has paid out except the causes

of action as the insolvent insurer would have had if it had paid those sums. If an insolvent insurer is operating on a plan with assessment liability, payments of association claims do not reduce the insureds' liability to the receiver, liquidator or statutory successor for unpaid assessments.

(b) The receiver, liquidator or statutory successor of an insolvent insurer is bound by settlements of covered claims by the association or a similar organization in another state. The court having jurisdiction shall grant those claims priority equal to that which the claimant would have been entitled in the absence of this chapter against the insolvent insurer's assets. The expense of the association or similar organization in handling claims shall be accorded the same priority as the liquidator's expenses.

(c) The association shall periodically file with the insolvent insurer's receiver or liquidator:

(i) Statements of the covered claims the association pays; and

(ii) Estimates of anticipated claims on the association which preserve the association's rights against the insolvent insurer's assets.

26-31-111. Exhaustion of remedies under policy; claims recoverable from more than one association; claim limitation.

(a) Any person having a claim against an insurer under an insurance policy other than a policy of an insolvent insurer which is also a covered claim, shall first exhaust his right under the policy. Any amount payable on a covered claim under this chapter shall be reduced by the amount of any recovery under the insurance policy.

(b) Any person having a claim which may be recovered under more than one (1) insurance guaranty association or its equivalent shall seek recovery first from the association of the insured's place of residence, except that if it is a first party claim for damage to property with a permanent location, he shall seek recovery first from the association of the location of the property. If it is a worker's compensation claim, he shall seek recovery first from the association of the claimant's residence. Any recovery under this chapter shall be reduced by the amount of recovery from any other insurance guaranty association or its equivalent.

(c) Notwithstanding any provision in this chapter, a covered claim shall not include any claim filed with the association after the earlier of:

(i) The final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer; or

(ii) Twenty-five (25) months after the date of the order of liquidation.

26-31-112. Aids in detection and prevention of insurer insolvencies.

(a) To aid in the detection and prevention of insurer insolvencies:

(i) The board of directors shall:

(A) Upon majority vote, notify the commissioner of any information indicating any member insurer may be insolvent or in a financial condition hazardous to the policyholders or the public;

(B) At the conclusion of any insurer insolvency in which the association is obligated to pay covered claims, prepare and submit to the commissioner, a report on the history and causes of the insolvency as determined by the available information.

(ii) The board of directors, upon majority vote, may:

(A) Request that the commissioner order an examination, as specified in subsection (b) of this section of any member insurer which the board in good faith believes may be in a financial condition hazardous to the policyholders or the public;

(B) Make reports and recommendations to the commissioner upon any matter germane to the solvency, liquidation, rehabilitation or conservation of any member insurer, and the reports and recommendations are not public documents;

(C) Make recommendations to the commissioner for the detection and prevention of insurer insolvencies.

(iii) It is the commissioner's duty to report to the board of directors when he has reasonable cause to believe that any member insurer examined or being examined at the board of directors' request may be insolvent or in a financial condition hazardous to the policyholders or the public.

(b) Within thirty (30) days from the date of receipt of a request for examination as specified in subparagraph (a)(ii)(A) of this section, 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 qualified persons the commissioner designates. The cost of the examination shall be paid by the association, and the examination report shall be treated as are other examination reports. The examination report shall 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 paragraph (a)(iii) of this section. 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 shall not be open to public inspection prior to the release of the examination report to the public.

26-31-113. Examination and regulation of association by commissioner; annual financial report.

The association is subject to the commissioner's examination and regulation. Not later than March 31 of each year, the board of directors shall submit a financial report for the preceding calendar year in a form the commissioner approves.

26-31-114. Exemption from payment of fees and taxes.

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 property.

26-31-115. Rates and premiums to be sufficient to recoup assessments paid to association.

The rates and premiums charged for insurance policies to which this chapter applies shall include amounts sufficient to recoup a sum equal to the amounts the member insurer pays to the association less any amounts the association returns to the member insurer. Rates containing an amount reasonably calculated to recoup assessments the member insurer pays are not excessive.

26-31-116. No liability for lawful action.

There is no liability on the part of and no cause of action of any nature shall arise against any member insurer, the association or its agents or employees, the board of directors or the commissioner or his representatives for any lawful action they take in the performance of their powers and duties under this chapter.

26-31-117. Stay of proceedings against insolvent insurer; setting aside judgment.

All proceedings in which the insolvent insurer is a party or is obligated to defend a party in any court in this state shall be stayed for sixty (60) days from the date the insolvency is determined to permit proper defense by the association of all pending causes of action. As to any covered claims arising from a judgment under any decision, verdict or finding based on the default of the insolvent insurer or its failure to defend an insured, the association either on its own behalf or on behalf of the insured may apply to have the judgment, order, decision, verdict or finding set aside by the same court or administrator making the judgment, order, decision, verdict or finding and may defend against the claim on the merits.

CHAPTER 32 - PREPAID OR PREARRANGED FUNERAL CONTRACTS

ARTICLE 1 - REGULATION OF PREPAID AND PREARRANGED FUNERAL CONTRACTS

26-32-101. Supervision and audit of funds; approval of investment; promulgation of rules and regulations; licenses.

(a) The department shall supervise and audit the funds derived by any person either residing in or doing business within the state, from prepaid or prearranged funeral contracts providing for the sale of caskets, burial vaults, monuments or memorials or any burial supplies and equipment and funeral services, if the sale is made, either outright or on the installment basis, prior to the demise of the person purchasing them or for whom they are purchased, with the merchandise or service, or both, to be delivered at a future date at time of need. All funds received from these contracts or arrangements by any person either residing in or doing business within this state shall be received, invested and withdrawn according to requirements the department approves. Investment in a bank,

trust company or federal savings and loan association in Wyoming is an approved investment. The deposit of funds received from the sale of these contracts or arrangements in irrevocable pre-need funeral trusts, the funds of which are invested in compliance with W.S. 4-10-901 and 4-10-902, is an approved investment. Earnings, including interest, income and dividends, from any investment of an irrevocable pre-need funeral trust may inure to the benefit of the seller of the prepaid or prearranged funeral contract, but shall be withdrawn from the irrevocable trust only upon the occurrence of an event that requires withdrawal of the corpus of the trust. Neither the person purchasing a prepaid or prearranged funeral contract nor any person for whom the contract is purchased shall be entitled to terminate or cancel the contract or make demand for the funds paid for the contract after the funds are deposited into an irrevocable pre-need funeral trust.

(b) The commissioner shall promulgate rules and regulations for the purposes specified in subsection (a) of this section to include regulation of contract provisions and funds thereunder. The rules shall require notice to buyers of prepaid or prearranged funeral contracts of the types of investments into which funds derived from the sale of these contracts may be deposited and the risks associated with those investments. The rules shall require notice to buyers of the ability to cancel or terminate a contract or make demand for any amounts paid for the contract. Rules promulgated by the commissioner shall not require any additional surety bond amount for those monies deposited in an irrevocable pre-need funeral trust and invested in compliance with W.S 4-10-902 beyond the minimum surety bond required of all persons deriving funds from prepaid or prearranged funeral contracts.

(c) A person shall not sell prepaid or prearranged funeral contracts in this state unless the person is licensed by the department in accordance with W.S. 26-9-203.

26-32-102. Exemption from attachment or garnishment.

In the absence of fraud no interest of any participant in such fund, contract or investment is liable to attachment, garnishment, or other processes, or shall be seized, taken, appropriated or applied by any legal or equitable process or operation of law to pay any debt or liability of the participant, or any other person who may have a right thereunder. Any funds received and invested as stipulated in this chapter shall be as a trust and are not liable to

attachment, garnishment or other processes, nor shall they be seized, taken or appropriated or applied by any legal or equitable processes or operation of law to pay any debt or liability of the person issuing the prepaid or prearranged funeral contract, or both.

26-32-103. Penalty.

Any person who violates any provision of this chapter is guilty of a misdemeanor, and upon conviction thereof, shall be punished by a fine of not more than five hundred dollars ($500.00) or by imprisonment for not more than six (6) months, or both.

ARTICLE 2 - LIFE INSURERS CONTRACTS FOR FUNERAL SERVICES

26-32-201. Life insurers contracts for funeral services; rules.

(a) A life insurer may contract or agree with any person, funeral director, mortuary or undertaker for the sole purpose of the funeral director, mortuary or undertaker conducting the funeral of any insured of the insurer.

(b) The commissioner shall by rule regulate contracts authorized under this section.

CHAPTER 33 - MEDICAL MALPRACTICE INSURANCE

26-33-101. Definitions.

(a) As used in this chapter:

(i) "Account" means the medical liability compensation account;

(ii) "Board" means the board of directors of the medical liability compensation account;

(iii) "Health care" means any act or treatment performed or furnished, or which should have been performed or furnished, by any physician for, to, or on behalf of a patient during the patient's medical care, treatment or confinement;

(iv) "Insurer" means an authority or an insurance company engaged in writing malpractice liability insurance in this state in accordance with this code;

(v) "Malpractice" means the rendering of or failure to render professional medical services as a result of which the patient has a cause of action against a licensed physician for monetary damages;

(vi) "Physician" means a person licensed by the state board of medicine to provide health care or professional services as a physician.

26-33-102. Qualification.

(a) To be qualified under this chapter, a physician shall annually purchase health care professional liability insurance coverage of not less than fifty thousand dollars ($50,000.00) per occurrence for any act, error or omission relating to medical care rendered during the policy year and pay the surcharge pursuant to W.S. 26-33-105(c).

(b) A physician failing to qualify under this section is not covered by this chapter.

26-33-103. Insurance coverage.

A qualified physician shall be insured in a minimum amount of fifty thousand dollars ($50,000.00) against a claim for malpractice. Any award or settlement adjudicated or allowed on a malpractice claim in excess of fifty thousand dollars ($50,000.00) or limits of other underlying coverage if greater occurring during any year in which the physician is qualified under this chapter shall be paid from the account subject to the limitation that obligations from the account shall not exceed one million dollars ($1,000,000.00) in any calendar year for one (1) or more awards or settlements against an individual physician.

26-33-104. Advance payments.

Any advance payment a defendant physician or his insurer makes to or for the plaintiff, or any other person, is not an admission of liability for injuries or damages the plaintiff or anyone else suffers as to a claim for malpractice. Evidence of an advance payment is not admissible in a court proceeding concerning malpractice until there is final determination in the plaintiff's favor, in which case the final amount payable shall be reduced by any advance payments.

26-33-105. Medical liability compensation account.

(a) There is created a medical liability compensation account, the monies of which shall be collected by the commissioner for exclusive use for the purposes stated in this chapter. The account and any investment income from it shall be held in trust and invested and reinvested by the state treasurer pursuant to W.S. 9-4-715(a), (d) and (e).

(b) The commissioner may use account monies to purchase insurance for the account and its obligations. The commissioner shall be notified of a suit within thirty (30) days from the date the suit is filed. The commissioner may participate in a physician's defense if any claim is sufficient to be a potential liability against the account. Reasonable legal expenses the board approves and the commissioner incurs in defense against any malpractice claim are payable out of the account.

(c) To create the account, all physicians qualified under W.S. 26-33-102, practicing in Wyoming and who elect to participate, shall pay an annual surcharge. The commissioner shall determine the surcharge based upon sound actuarial principles using data obtained from Wyoming experience. The surcharge shall not exceed one hundred fifty percent (150%) of the cost to each physician for a basic fifty thousand dollar ($50,000.00) malpractice insurance premium and shall be collected on the same basis as premiums by each insurer from the physician.

(d) The surcharge is due and payable within thirty (30) days after the insurer receives the premiums for malpractice liability insurance from the practicing physician in Wyoming. The commissioner shall send to each insurer a statement explaining the provisions of this section together with any other information necessary for their compliance with this section.

(e) If the insurer collects the annual premium surcharge but does not pay it to the state within the stated time limit, the commissioner may suspend the insurer's certificate of authority until the annual premium surcharge is paid.

(f) All expenses of collecting, protecting and administering the account or related to the purchase of insurance for the account shall be paid from the account. The commissioner may employ financial, administrative or legal consultants to assist in the account management.

(g) If the account balance exceeds four million dollars ($4,000,000.00) at the end of any calendar year after payment of all claims and expenses, the commissioner shall reduce the surcharge to maintain the account at an approximate level of four million dollars ($4,000,000.00).

(h) The commissioner shall purchase reinsurance, if needed, to protect the account from depletion due to judgment against it. The reinsurance so purchased shall cover each qualified physician from two hundred fifty thousand dollars ($250,000.00) to one million dollars ($1,000,000.00) per year. Cost of reinsurance shall be paid from the monies of the account.

26-33-106. Board created; membership; removal; terms; duties.

(a) There is created a medical liability compensation account board which shall consist of six (6) members. The governor shall appoint four (4) members with the advice and consent of the senate. The state treasurer and the commissioner are the other voting members. The governor may remove any member he appoints as provided in W.S. 9-1-202.

(b) Of the members the governor appoints:

(i) One (1) shall be a physician licensed to practice in Wyoming by the state board of medicine;

(ii) One (1) shall be a practicing attorney licensed to practice in Wyoming by the Wyoming state bar;

(iii) One (1) shall be a health care consumer; and

(iv) One (1) shall be a licensed insurance agent in Wyoming.

(c) Two (2) members shall serve for terms ending two (2) years from January 1 immediately following their appointment and two (2) members shall serve for a term of four (4) years from that date. Their successors shall serve for terms of three (3) years each. Effective July 1, 1979, appointments and terms shall be in accordance with W.S. 28-12-101 through 28-12-103.

(d) The board shall administer and govern the account and shall file rules and regulations therefor with the secretary of state.

26-33-107. Settlements.

Any settlement of a claim against a physician exceeding fifty thousand dollars ($50,000.00) or limits of other underlying coverage if greater shall be carried out through agreement jointly by the claimant, the insurance carrier and the commissioner. If the claimant settles with the insurance carrier, without including the commissioner in the settlement agreement, the claimant waives any claim for damages exceeding fifty thousand dollars ($50,000.00) or limits of other underlying coverage if greater arising from the incident for which the claim is made.

26-33-108. Payments from account.

The state auditor, at the direction of the commissioner, shall issue a warrant in satisfaction of each claim submitted to him against the account after receipt of a certified copy of a final judgment from a court having jurisdiction, or a settlement agreement signed by a claimant, a qualified representative of the insurance carrier and the commissioner, with original signatures. The warrant shall be for the amount exceeding fifty thousand dollars ($50,000.00) or limits of other underlying coverage, if greater, set forth in the judgment or settlement, subject to the limitation that the amounts paid from the account shall not exceed one million dollars ($1,000,000.00) in any calendar year for one (1) or more awards or settlements against an individual physician.

26-33-109. Contents of policies.

Any policy issued under this chapter is presumed to comply with this chapter. The insurer assumes all obligations to pay an award imposed against its insured under this chapter and no policy termination by cancellation is effective unless at least ninety (90) days before the effective date of the cancellation both the insured and the commissioner receive at their offices, a written notice giving the date upon which termination is effective.

26-33-110. Failure to pay claims.

(a) If a professional liability insurer, in the regular course of business, fails to pay its portion of any judgment rendered against any physician or any other person insured under this chapter, the commissioner shall suspend that insurer's

certificate of authority until the portion of the judgment allocable to the insurer is paid in full, provided the insurer has the right to a hearing in accordance with W.S. 26-3-115(b).

(b) This section does not apply:

(i) If the insurer has asserted against the physician any policy defense based upon misrepresentation, fraud, noncooperation or any other matter which constitutes an avoidance of the policy;

(ii) If the time for filing any petition for review, new trial, appeal or rehearing, or all of them has not expired; or

(iii) Until such time as all review or appellate decisions are final.

26-33-111. Exemption from Wyoming Insurance Guaranty Association Act.

This chapter is exempt from and has no application to the Wyoming Insurance Guaranty Association Act.

CHAPTER 34 - HEALTH MAINTENANCE ORGANIZATIONS

26-34-101. Short title.

This chapter is known and may be cited as "The Health Maintenance Organization Act of 1995".

26-34-102. Definitions.

(a) As used in this chapter:

(i) "Administrator" means the director of the department of health;

(ii) "Basic health care services" means emergency care, inpatient hospital and physician care, and outpatient medical services, but does not include mental health services or services for alcohol or drug abuse;

(iii) "Capitated basis" means fixed per member per month payment or percentage of premium payment wherein the provider assumes the full risk for the cost of contracted services without regard to the type, value or frequency of

services provided. For purposes of this definition, "capitated basis" includes the cost associated with operating staff model facilities;

(iv) "Carrier" means a health maintenance organization, an insurer, a hospital and medical service corporation or other entity responsible for the payment of benefits or the provision of services under a group contract;

(v) "Commissioner" means the insurance commissioner of this state;

(vi) "Coinsurance" means a percentage of eligible charges payable by an enrollee directly to a provider for covered services rendered;

(vii) "Copayment" means an amount an enrollee must pay in order to receive a specific service which is not fully prepaid;

(viii) "Deductible" means the amount an enrollee is responsible to pay out-of-pocket before the health maintenance organization begins to pay the costs associated with treatment;

(ix) "Discontinuance" means the termination of the contract between the group contract holder and a health maintenance organization due to the insolvency of the health maintenance organization, and does not refer to the termination of any agreement between any individual enrollee and the health maintenance organization;

(x) "Enrollee" means an individual who is enrolled in a health maintenance organization;

(xi) "Evidence of coverage" means any certificate, agreement or contract issued to an enrollee setting out the coverage to which the enrollee is entitled;

(xii) "Extension of benefits" means the continuation of coverage under a particular benefit provided under a contract following termination with respect to an enrollee who is totally disabled on the date of termination;

(xiii) "Group contract" means a contract for health care services which by its terms limits eligibility to members of a specified group. The group contract may include coverage for dependents;

(xiv) "Group contract holder" means the person to which a group contract has been issued;

(xv) "Health care services" means any services included in the furnishing to any individual of medical or dental care, vision care or hospitalization or incident to the furnishing of that care or hospitalization, as well as the furnishing to any person of any other services for the purpose of preventing, alleviating, curing or healing human illness, injury or physical disability;

(xvi) "Health maintenance organization" means any person, except a person offering a dental only or vision only plan, who undertakes to provide or arrange for basic health care services to enrollees on a prepaid basis, except for enrollee responsibility for copayments, coinsurance or deductibles, and may include providing or arranging for:

(A) Physician services directly through physician employees or under arrangements with individual physicians or groups of physicians;

(B) Other health care services on a prepayment or other financial basis.

(xvii) "Health maintenance organization producer" means a person who solicits, negotiates, effects, procures, delivers, renews or continues a policy or contract for health maintenance organization membership, or who takes or transmits a membership fee or premium for such a policy or contract, other than for himself, or a person who advertises or otherwise holds himself out to the public as undertaking any of the activities of a health maintenance organization producer;

(xviii) "Individual contract" means a contract for health care services issued to and covering an individual. The individual contract may include dependents of the subscriber;

(xix) "Insolvent" or "insolvency" means that the organization has been declared insolvent and placed under an order of liquidation by a court of competent jurisdiction;

(xx) "Managed hospital payment basis" means agreements under which the financial risk is primarily related to the degree of utilization rather than to the cost of services;

(xxi) "Net worth" means the excess of total admitted assets over total liabilities, but the liabilities shall not include fully subordinated debt;

(xxii) "Participating provider" means a provider as defined in paragraph (xxiv) of this subsection who, under an express or implied contract with the health maintenance organization or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than copayment, coinsurance or deductible, directly or indirectly from the health maintenance organization;

(xxiii) "Person" means as defined by W.S. 26-1-102(a)(xx);

(xxiv) "Provider" means any physician, hospital or other person which is licensed or otherwise authorized to furnish health care services in the state in which the services are rendered;

(xxv) "Replacement coverage" means the benefits provided by a succeeding carrier;

(xxvi) "Subscriber" means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the health maintenance organization, or in the case of an individual contract, the person in whose name the contract is issued;

(xxvii) "Uncovered expenditures" means the costs to the health maintenance organization for health care services that are the obligation of the health maintenance organization, for which an enrollee may also be liable in the event of the health maintenance organization's insolvency and for which no alternative arrangements have been made that are acceptable to the commissioner;

(xxviii) "This code" means title 26 of the Wyoming statutes;

(xxix) "This act" means W.S. 26-34-101 through 26-34-134.

26-34-103. Establishment of health maintenance organizations.

(a) Notwithstanding any law of this state to the contrary, any person may apply to the commissioner for a certificate of authority to establish and operate a health maintenance organization in compliance with this chapter. No person shall establish or operate a health maintenance organization in this state, without obtaining a certificate of authority under this chapter.

(b) Any health maintenance organization in operation as of July 1, 1995, shall submit an application for a certificate of authority under this section not later than August 1, 1995. Each applicant may continue to operate until the commissioner acts upon the application. If an application is denied under W.S. 26-34-104, the applicant shall be treated as a health maintenance organization whose certificate of authority has been revoked.

(c) Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, shall be in a form the commissioner prescribes and shall set forth or be accompanied by the following:

(i) A copy of the applicant's organizational documents, such as the articles of incorporation, articles of association, partnership agreement, trust agreement or other applicable documents, and all amendments thereto;

(ii) A copy of the bylaws, rules and regulations or similar document, if any, regulating the conduct of the applicant's internal affairs;

(iii) A list of the names, addresses, biographical information and official positions of the persons who are to be responsible for the conduct of the applicant's affairs, 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;

(iv) A copy of any contract made or to be made between any providers, third party administrators, marketing consultants or persons listed in paragraph (iii) of this subsection and the health maintenance organization;

(v) A copy of the form of evidence of coverage to be issued to the enrollees;

(vi) A copy of the form or group contract, if any, which is to be issued to employers, unions, trustees or other organizations;

(vii) Financial statements prepared in conformity with the requirements of this code showing the applicant's assets, liabilities and sources of financial support. A copy of the applicant's most recent certified financial statement and an unaudited current financial statement shall be included;

(viii) A financial feasibility plan which includes detailed enrollment projections, the methodology for determining premium rates to be charged during the first twelve (12) months of operations certified by an actuary or other qualified person, a projection of balance sheets, cash flow statements showing any capital expenditures, purchase and sale of investments and deposits with the state and income and expense statements anticipated from the start of operations until the organization has had net income for at least one (1) year and a statement as to the sources of working capital as well as any other sources of funding;

(ix) A power of attorney executed by the applicant, if not domiciled in this state, appointing the commissioner and his successors in office, and authorized deputies, as the true and lawful attorney of the applicant in and for this state upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this state may be served;

(x) A statement reasonably describing the geographic area or areas to be served;

(xi) A description of the complaint procedures to be used as required under W.S. 26-34-112;

(xii) A description of the procedures and programs to be implemented to meet the quality of health care requirements in W.S. 26-34-104(b);

(xiii) Repealed by Laws 1995, ch. 210, § 5.

(xiv) A description of the procedures to be implemented to meet the protection against insolvency requirements in W.S. 26-34-114;

(xv) A list of the names, addresses and professional license numbers of all providers with which the health maintenance organization has agreements;

(xvi) A description of the quality assurance program and the mechanisms in place to assure availability, accessibility and continuity of care required under W.S. 26-34-108;

(xvii) Any other information the commissioner requires to make the determinations specified in W.S. 26-34-104.

(d) Any applicant or health maintenance organization holding a certificate of authority granted under this chapter, unless otherwise provided for in this chapter, shall file a notice describing any material modification of the operation set out in the information required by subsection (c) of this section. The notice shall be filed with the commissioner prior to the modification. If the commissioner does not disapprove within forty-five (45) days of filing, the modification is deemed approved.

(e) The commissioner may promulgate rules and regulations exempting from the filing requirements of subsection (a) of this section those items he deems unnecessary.

(f) Any applicant or health maintenance organization holding a certificate of authority granted under this chapter shall file all contracts of reinsurance with the commissioner. Any agreement between the organization and an insurer is subject to the requirements of this code regarding reinsurance. All reinsurance agreements and any modifications thereto shall be filed and approved before the effective date of any agreement or modification. Reinsurance agreements shall remain in full force and effect for at least ninety (90) days following written notice to the commissioner, by registered mail, of cancellation by either party.

26-34-104. Issuance of certificate of authority.

(a) Upon receipt of an application for issuance of a certificate of authority, the commissioner shall immediately

transmit a copy of the application and accompanying documents to the administrator.

(b) The administrator shall determine whether the applicant for a certificate of authority, with respect to health care services to be furnished has complied with W.S. 26-34-108.

(i) Repealed by Laws 1995, ch. 210, § 5.

(ii) Repealed by Laws 1995, ch. 210, § 5.

(iii) Repealed by Laws 1995, ch. 210, § 5.

(c) Within forty-five (45) days of receipt of the application for issuance of a certificate of authority, the administrator shall certify to the commissioner that the proposed health maintenance organization meets the requirements of W.S. 26-34-108 or notify the commissioner that the health maintenance organization does not meet the requirements and specify in what respects it is deficient.

(d) The commissioner shall issue or deny a certificate of authority to any person filing an application pursuant to W.S. 26-34-103 within fifteen (15) days of receipt of the certification from the administrator. Issuance of a certificate of authority shall be granted upon payment of the application fee prescribed in W.S. 26-34-126 if the commissioner is satisfied that the following conditions are met:

(i) The persons responsible for the conduct of the applicant's affairs are competent and trustworthy;

(ii) The administrator certifies that the health maintenance organization's proposed plan of operation meets the requirements of W.S. 26-34-108;

(iii) The health maintenance organization shall 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, coinsurance and deductibles;

(iv) 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 arrangements for health care services and the schedule of premiums used in connection therewith;

(B) The adequacy of working capital;

(C) Any agreement with an insurer, a hospital or medical service corporation, a government or any other organization or entity 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 health maintenance organization;

(D) Any agreement with providers for the provision of health care services; and

(E) Any deposit of cash or securities submitted in accordance with W.S. 26-34-114.

(v) Repealed by Laws 1995, ch. 210, § 5.

(vi) Nothing in the proposed method of operation, as shown by the information submitted pursuant to W.S. 26-34-103 or by independent investigation, is contrary to the public interest; and

(vii) Any deficiencies identified by the administrator have been corrected.

(e) A certificate of authority shall be denied only after compliance with the requirements of W.S. 26-34-125.

26-34-105. Powers of health maintenance organizations.

(a) The powers of a health maintenance organization include but are not limited to the:

(i) Purchase, lease, construction, renovation, operation or maintenance of hospitals or medical facilities, or both, and their ancillary equipment, and any property as may reasonably be required for its principal office or for any purposes as may be necessary in the transaction of the business of the organization;

(ii) 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 and hospitals or in furtherance of a program providing health care services to enrollees;

(iii) Furnishing of health care services through providers which are under contract with or employed by the health maintenance organization;

(iv) Contracting with any person for the performance on its behalf of certain functions such as marketing, enrollment and administration;

(v) Contracting with an insurance company licensed in this state, or with a hospital or 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;

(vi) Offering of other health care services, in addition to basic health care services. Nonbasic health care services may be offered by a health maintenance organization on a prepaid basis without offering basic health care services to any group or individual;

(vii) The joint marketing of products with an insurance company licensed in this state or with a hospital or medical service corporation authorized to do business in this state as long as the company that is offering each product is clearly identified.

(b) A health maintenance organization shall file notice, with adequate supporting information, with the commissioner prior to the exercise of any power granted in paragraph (a)(i), (ii) or (iv) of this section. The commissioner shall disapprove any exercise of power only if in his 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 forty-five (45) days from the date of the filing, it is deemed approved.

(c) The commissioner may promulgate rules and regulations exempting from the filing requirement of subsection (b) of this section those activities having a de minimis effect.

26-34-106. Governing body.

(a) The governing body of any health maintenance organization may include providers, or other individuals, or both.

(b) Repealed by Laws 1995, ch. 210, § 5.

(c) Any domestic health maintenance organization shall comply with the requirements applicable to a domestic insurer in W.S. 26-24-129 and shall be subject to the penalties provided in W.S. 26-24-129.

26-34-107. Fiduciary responsibilities.

(a) Any director, officer, employee or partner of a health maintenance organization who receives, handles, collects, disburses or invests funds in connection with the activities of the organization is responsible for those funds in a fiduciary relationship to the organization and shall not violate the prohibitions specified in W.S. 26-24-127.

(b) A health maintenance organization shall maintain in force a fidelity bond on employees and officers in an amount not less than the greater of two hundred fifty thousand dollars ($250,000.00), ten percent (10%) of the organization's previous year's gross premiums or other amount the commissioner prescribes. All such bonds shall be written with at least a one (1) year discovery period and if written with less than a three (3) year discovery period shall contain a provision that no cancellation or termination of the bond, whether by or at the request of the insured or by the underwriter is effective prior to the expiration of ninety (90) days after written notice of the cancellation or termination has been filed with the commissioner unless the commissioner approves an earlier date of cancellation or termination.

(c) A health maintenance organization shall not make any disbursement of seventy-five dollars ($75.00) or more without complying with the requirements specified for insurers in W.S. 26-24-130.

26-34-108. Quality assurance program.

(a) The health maintenance organization shall establish procedures to assure that the health care services provided to enrollees are rendered under reasonable standards of quality of care consistent with prevailing professionally recognized standards of medical practice. The procedures shall include

mechanisms to assure availability, accessibility and continuity of care.

(b) The health maintenance organization shall have an ongoing internal quality assurance program to monitor and evaluate its health care services, including primary and specialist physician services, and ancillary and preventive health care services, across all institutional and noninstitutional settings. The program shall include, at a minimum, the following:

(i) A written statement of goals and objectives which emphasizes improved health status in evaluating the quality of care rendered to enrollees;

(ii) A written quality assurance plan which describes the following:

(A) The health maintenance organization's scope and purpose in quality assurance;

(B) The organizational structure responsible for quality assurance activities;

(C) Contractual arrangements, where appropriate, for delegation of quality assurance activities;

(D) Confidentiality policies and procedures;

(E) A system of ongoing evaluation activities;

(F) A system of focused evaluation activities;

(G) A system for credentialing providers and performing peer review activities; and

(H) Duties and responsibilities of the designated physician responsible for the quality assurance activities.

(iii) A written statement describing the system of ongoing quality assurance activities including:

(A) Problem assessment, identification, selection and study;

(B) Corrective action, monitoring, evaluation and reassessment; and

(C) Interpretation and analysis of patterns of care rendered to individual patients by individual providers.

(iv) A written statement describing the system of focused quality assurance activities based on representative samples of the enrolled population which identifies method of topic selection, study, data collection, analysis, interpretation and report format; and

(v) Written plans for taking appropriate corrective action whenever, as determined by the quality assurance program, inappropriate or substandard care or services have been provided, or care or services which should have been furnished have not been provided.

(c) The organization shall record proceedings of formal quality assurance program activities and maintain documentation in a confidential manner. Quality assurance program minutes shall be available to the administrator. Contents of the minutes shall be confidential to the extent confidentiality is provided under the provisions of W.S. 16-4-203(d)(i) and (vii), 26-34-129, 26-34-130, 35-2-910 or 35-17-105.

(d) The organization shall ensure the use and maintenance of an adequate patient record system which will facilitate documentation and retrieval of clinical information for the purpose of the health maintenance organization evaluating continuity and coordination of patient care and assessing the quality of health and medical care provided to enrollees.

(e) Enrollee clinical records shall be available to the administrator or an authorized designee for examination and review to ascertain compliance with this section, or as deemed necessary by the administrator.

(f) The organization shall establish a mechanism for periodic reporting of quality assurance program activities to the governing body, providers and appropriate organization staff.

26-34-109. Requirements for group contract, individual contract, evidence of coverage and premiums for health care services.

(a) Every group and individual contract holder is entitled to a group or individual contract. The contract shall not contain provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, or which encourage misrepresentation as defined by W.S. 26-34-117(a). The contract shall contain a clear statement of the following:

(i) Name and address of the health maintenance organization;

(ii) Eligibility requirements;

(iii) Benefits and services within the service area;

(iv) Emergency care benefits and services;

(v) Out of area benefits and services, if any;

(vi) Copayments, coinsurance, deductibles or other out-of-pocket expenses;

(vii) Limitations and exclusions, including an explanation of any prescription drug benefits not provided for under a specified health plan;

(viii) Enrollee termination;

(ix) Enrollee reinstatement, if any;

(x) Claims procedures;

(xi) Enrollee complaint procedures;

(xii) Continuation of coverage;

(xiii) Conversion;

(xiv) Extension of benefits, if any;

(xv) Coordination of benefits, if applicable;

(xvi) Subrogation, if any;

(xvii) Description of the service area;

(xviii) Entire contract provision;

(xix) Term of coverage;

(xx) Cancellation of group or individual contract holder;

(xxi) Renewal;

(xxii) Reinstatement of group or individual contract holder, if any;

(xxiii) Grace period as provided in W.S. 26-18-107;

(xxiv) Conformity with state law; and

(xxv) Any withholding agreement pertaining to health care delivery services which requires reimbursement to the provider at a later date dependent upon decisions regarding coverage. The agreement shall specify the requirements in detail. If the existence of a withholding agreement has been disclosed in the contract, the health maintenance organization may alter the terms of the agreement without being deemed to alter the terms of the contract provided the contract holder is notified in detail of the new terms of the agreement at his next renewal.

(b) In addition to those provisions required in subsection (a) of this section, an individual contract shall provide for a ten (10) day period to examine and return the contract and have the premium refunded. If services were received during the ten (10) day period, and the person returns the contract to receive a refund of the premium paid, he shall pay for the services.

(c) Each enrollee residing in this state shall receive an evidence of coverage from the group contract holder or the health maintenance organization. The evidence of coverage shall not contain provisions or statements which are unfair, unjust, inequitable, misleading, deceptive or which encourage misrepresentation as defined by W.S. 26-34-117(a). The evidence of coverage shall contain:

(i) A clear statement of the provisions required in paragraphs (a)(i) through (xvii) of this section; and

(ii) A provision that any subsequent material change shall be evidenced in a separate document issued to the enrollee.

(d) No group or individual contract, evidence of coverage, or amendment thereto, shall be issued or delivered to any person in this state:

(i) Until a copy of the form of the contract, evidence of coverage, or amendment thereto, has been filed with and approved by the commissioner.

(e) Every form required by this section shall be filed with the commissioner not less than forty-five (45) days prior to delivery or issue for delivery in this state. At any time during the initial forty-five (45) day period, the commissioner may extend the period for review for an additional forty-five (45) days. Notice of an extension shall be in writing. At the end of the review period, the form is deemed approved if the commissioner has taken no action. The filer shall notify the commissioner in writing prior to using a form that is deemed approved.

(f) At any time, after thirty (30) days notice and for cause shown, the commissioner may withdraw approval of any form, effective at the end of thirty (30) days.

(g) When a filing is disapproved or approval of a form is withdrawn, the commissioner shall give the health maintenance organization written notice of the reasons for disapproval and in the notice shall inform the health maintenance organization that within thirty (30) days of receipt of the notice the health maintenance organization may request a hearing. A hearing shall be conducted within thirty (30) days after the commissioner has received the request for hearing.

(h) The commissioner may adopt regulations establishing readability standards for individual contract, group contract, and evidence of coverage forms.

(j) No schedule of premiums or methodology for determining a schedule of premiums for enrollee coverage for health care services, or amendment thereto, may be used until a copy of that schedule, or amendment thereto, has been filed with and approved by the commissioner.

(k) Premiums or methodology for determining a schedule of premiums shall be established in accordance with actuarial principles for various categories of enrollees, provided that premiums applicable to an enrollee may not be individually determined based on the status of his health. However, the

premiums shall not be excessive, inadequate or unfairly discriminatory. A certification, by a qualified actuary or other qualified person acceptable to the commissioner, to the appropriateness of the use of the methodology, based on reasonable assumptions, shall accompany the filing along with adequate supporting information.

(m) The commissioner, within a reasonable period, shall approve any form if the requirements of subsections (a) through (g) of this section are met and any schedule of premiums if the requirements of subsections (j) and (k) of this section are met. It is unlawful to issue a form or to use the schedule of premiums until approved or deemed approved.

(n) The commissioner may require the submission of whatever relevant information he deems necessary in determining whether to approve or disapprove a filing made pursuant to this section.

26-34-110. Annual report.

(a) Each health maintenance organization, annually, on or before March 1, shall file with the commissioner, with a copy to the administrator, a report verified by at least two (2) organization principal officers and covering the immediately preceding calendar year. Each health maintenance organization shall file with the commissioner on a quarterly basis a statement of its financial condition for the preceding quarter. Each quarterly statement shall be filed with the commissioner on or before forty-five (45) days from the end of the quarter being reported. The reports and statements shall be on forms the commissioner prescribes and shall be completed pursuant to the most recent National Association of Insurance Commissioners' accounting practices and procedures manual.

(b) The health maintenance organization shall file on or before March 1, unless otherwise stated:

(i) Audited financial statements in accordance with the provisions of title 26, chapter 3, article 3 of the Wyoming statutes on or before June 1;

(ii) A list of the providers who have executed a contract that complies with W.S. 26-34-114; and

(iii) The report on the complaint system pursuant to W.S. 26-34-112(b).

(c) All annual and quarterly statements filed pursuant to this section shall be accompanied by an electronic version containing the same information as the statement. The commissioner may specify the format of the electronic version. The commissioner may accept, for any health maintenance organization not domiciled in this state which is required to file annual, quarterly and audited financial statements under this section, an electronic filing with the National Association of Insurance Commissioners meeting the requirements of this section as a filing with the commissioner. The commissioner may refuse to continue or may suspend or revoke the certificate of authority of any health maintenance organization failing to file its annual or quarterly statement when due.

(d) The commissioner may require any additional reports as are deemed reasonably necessary and appropriate to enable him to carry out his duties under this chapter.

26-34-111. Information to enrollees; claims to be accepted or rejected; attorney's fees.

(a) Each health maintenance organization shall:

(i) Provide promptly to its enrollees notice of any material change in the operation of the organization that will directly affect those enrollees;

(ii) Provide to its subscribers a list of providers, upon enrollment and reenrollment;

(iii) Notify an enrollee in writing of the termination of the primary care provider who provided health care services to that enrollee, and provide assistance to the enrollee in transferring to another participating primary care provider;

(iv) Provide to subscribers information on how services may be obtained, where additional information on access to services can be obtained and a telephone number where the enrollee can contact the organization at no cost to the enrollee.

(b) Any claim for a benefit under a health insurance policy shall be rejected or accepted and paid by the health maintenance organization in accordance with W.S. 26-15-124(a) and (c).

26-34-112. Complaint system.

(a) Each health maintenance organization shall establish and maintain a complaint system which has been approved by the commissioner, after consultation with the administrator, to provide reasonable procedures for the resolution of written complaints initiated by enrollees.

(b) Each health maintenance organization shall submit to the commissioner and the administrator, an annual report, in a form the commissioner prescribes, after consultation with the administrator, which shall include:

(i) A description of the procedures of the complaint system;

(ii) The total number of complaints handled through the complaint system and a compilation of causes underlying the complaints filed; and

(iii) The number, amount and disposition of malpractice claims made by an enrollee of the organization that were settled during the year by the health maintenance organization. All such information shall be held in confidence by the commissioner.

(c) The commissioner or the administrator may examine the complaint system at any time.

26-34-113. Investments.

With the exception of investments made in accordance with W.S. 26-34-105(a)(i), the funds of a health maintenance organization shall be invested only in securities or other investments permitted by chapter 7 of this code.

26-34-114. Protection against insolvency.

(a) Before issuing any certificate of authority, the commissioner shall require that the health maintenance organization have an initial net worth of one million five hundred thousand dollars ($1,500,000.00) and shall thereafter maintain the minimum net worth required under subsection (b) of this section.

(b) Except as provided in subsection (c) of this section, every health maintenance organization must maintain a minimum net worth equal to the greater of:

(i) Two percent (2%) of annual premium revenues as reported on the most recent annual financial statement filed with the commissioner on the first seventy-five million dollars ($75,000,000.00) of premium and one percent (1%) of annual premium revenues on the premium in excess of seventy-five million dollars ($75,000,000.00);

(ii) Three (3) times the average monthly uncovered health care expenditures as reported on the most recent financial statement filed with the commissioner;

(iii) One million dollars ($1,000,000.00); or

(iv) An amount equal to the sum of:

(A) Eight percent (8%) of annual health care expenditures except those paid on a capitated basis or managed hospital payment basis as reported on the most recent financial statement filed with the commissioner; and

(B) Four percent (4%) of annual hospital expenditures paid on a managed hospital payment basis as reported on the most recent financial statement filed with the commissioner.

(c) A health maintenance organization licensed before July 1, 1995 shall maintain a minimum net worth of:

(i) Twenty-five percent (25%) of the amount required by subsection (b) of this section by December 31, 1995;

(ii) Fifty percent (50%) of the amount required by subsection (b) of this section by December 31, 1996;

(iii) Seventy-five percent (75%) of the amount required by subsection (b) of this section by December 31, 1997;

(iv) One hundred percent (100%) of the amount required by subsection (b) of this section by December 31, 1998.

(d) In determining net worth, no debt shall be considered fully subordinated unless the subordination clause is in a form acceptable to the commissioner. Any interest obligation

relating to the repayment of any subordinated debt must be similarly subordinated.

(e) The interest expenses relating to the repayment of any fully subordinated debt shall be considered covered expenses.

(f) Any fully subordinated debt incurred by a note meeting the requirements of subsections (d) and (e) of this section, and otherwise acceptable to the commissioner, shall not be considered a liability and shall be recorded as equity.

(g) Unless otherwise provided in this section, each health maintenance organization shall deposit with the commissioner or, at the discretion of the commissioner, with any organization or trustee acceptable to him through which a custodial or controlled account is utilized, cash, securities or any combination of these or other measures that are acceptable to him which at all times shall have a value of not less than three hundred thousand dollars ($300,000.00).

(h) An organization that is in operation on July 1, 1995, shall make a deposit of cash, securities, combination thereof or other measures of equal amount acceptable to the commissioner of one hundred fifty thousand dollars ($150,000.00) on or before August 1, 1995, and an additional deposit of cash, securities, combination thereof or other measures of equal amount acceptable to the commissioner of one hundred fifty thousand dollars ($150,000.00) on or before July 1, 1996.

(j) The deposit shall be an admitted asset of the health maintenance organization in the determination of net worth. All income from deposits belongs to the depositing organization, shall be paid to it as it becomes available and shall be an asset of the organization. A health maintenance organization that has made a securities deposit may withdraw that deposit or any part thereof after making a substitute deposit of cash, securities or any combination thereof or other measures of equal amount and value. Any securities shall be approved by the commissioner before being substituted.

(k) The deposit shall be used to protect the interests of the health maintenance organization's enrollees and to assure continuation of health care services to enrollees of a health maintenance organization which is in rehabilitation or conservation. The commissioner may use the deposit for administrative costs directly attributable to a receivership or liquidation. If the health maintenance organization is placed

in receivership or liquidation, the deposit shall be an asset subject to chapter 28 of this code.

(m) The commissioner may reduce or eliminate any of the deposit requirements set forth in this section if he is satisfied that the health maintenance organization has deposited with the state treasurer, insurance commissioner, or other official body of the state or jurisdiction of domicile for the protection of all subscribers and enrollees, wherever located, of the health maintenance organization, cash, acceptable securities or surety, and delivers to the commissioner a certificate to that effect, duly authenticated by the appropriate state official holding the deposit.

(n) Every health maintenance organization shall, when determining liabilities, include an amount estimated in the aggregate to provide for any unearned premium and for the payment of all claims for health care expenditures which have been incurred, whether reported or unreported, which are unpaid and for which the organization is or may be liable, and to provide for the expense of adjustment or settlement of those claims. The liabilities shall be computed in accordance with accounting principles established by the commissioner upon reasonable consideration of the ascertained experience and character of the health maintenance organization.

(o) Every contract between a health maintenance organization and a participating provider of health care services shall be in writing and shall set forth that in the event the health maintenance organization fails to pay for health care services as set forth in the contract, the subscriber or enrollee shall not be liable to the provider for any sums owed by the health maintenance organization.

(p) In the event that the participating provider contract has not been reduced to writing as required by this section or that the contract fails to contain the required prohibition, the participating provider shall not collect or attempt to collect from the subscriber or enrollee sums owed by the health maintenance organization.

(q) No participating provider, or agent, trustee or assignee thereof, may maintain any action at law against a subscriber or enrollee to collect sums owed by the health maintenance organization.

(r) The commissioner shall require that each health maintenance organization have a plan for handling insolvency which allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to members who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits. In considering such a plan, the commissioner may require:

(i) Insurance to cover the expenses to be paid for continued benefits after an insolvency;

(ii) Provisions in provider contracts that obligate the provider to provide services for the duration of the period after the health maintenance organization's insolvency for which premium payment has been made and until the enrollees' discharge from inpatient facilities;

(iii) Insolvency reserves;

(iv) Acceptable letters of credit;

(v) Any other arrangements to assure that benefits are continued as specified in this subsection.

(s) An agreement to provide health care services between a provider and a health maintenance organization shall require that if the provider terminates the agreement, the provider shall give the organization at least sixty (60) days advance notice of termination.

26-34-115. Uncovered expenditures insolvency deposit.

(a) If at any time uncovered expenditures exceed ten percent (10%) of total health care expenditures, a health maintenance organization shall place an uncovered expenditures insolvency deposit with the commissioner, or with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is maintained, cash or securities that are acceptable to the commissioner. The deposit shall at all times have a fair market value in an amount of one hundred twenty percent (120%) of the organization's outstanding liability for uncovered expenditures for enrollees in this state, including incurred but not reported claims, and shall be calculated as of the first day of the month and maintained for the remainder of the month. If a health maintenance organization is not otherwise required to file a quarterly

report, it shall file a report within forty-five (45) days of the end of the calendar quarter with information sufficient to demonstrate compliance with this section.

(b) The deposit required under this section is in addition to the deposit required under W.S. 26-34-114(g) and (h) and is an admitted asset of the health maintenance organization in the determination of net worth. All income from such deposits or trust account shall be assets of the health maintenance organization and may be withdrawn quarterly with the approval of the commissioner.

(c) A health maintenance organization that has made a deposit may withdraw that deposit or any part of the deposit if:

(i) A substitute deposit of cash or securities of equal amount and value is made;

(ii) The fair market value exceeds the amount of the required deposit; or

(iii) The required deposit under subsection (a) of this section is reduced or eliminated.

(d) Deposits, substitutions or withdrawals may be made only with the prior written approval of the commissioner.

(e) The deposit required under this section is in trust and may be used only as provided under this section. The commissioner may use the deposit of an insolvent health maintenance organization for administrative costs associated with administering the deposit and payment of claims of enrollees of this state for uncovered expenditures in this state. Claims for uncovered expenditures shall be paid on a pro rata basis based on assets available to pay the ultimate liability for incurred expenditures. Partial distribution may be made pending final distribution. Any amount of the deposit remaining shall be paid into the liquidation or receivership of the health maintenance organization.

(f) The commissioner may by regulation prescribe the time, manner and form for filing claims under subsection (e) of this section.

(g) The commissioner may by regulation or order require health maintenance organizations to file annual, quarterly or more frequent reports as he deems necessary to demonstrate

compliance with this section. The commissioner may require that the reports include liability for uncovered expenditures as well as an audit opinion.

26-34-116. Enrollment period, replacement coverage in the event of insolvency.

(a) In the event of an insolvency of a health maintenance organization, upon order of the commissioner all other carriers that participated in the enrollment process with the insolvent health maintenance organization at a group's last regular enrollment period shall offer the group's enrollees of the insolvent health maintenance organization a thirty (30) day enrollment period commencing upon the date of insolvency. Each carrier shall offer the enrollees of the insolvent health maintenance organization the same coverages and rates that it had offered to the enrollees of the group at its last regular enrollment period.

(b) If no other carrier had been offered to some groups enrolled in the insolvent health maintenance organization, or if the commissioner determines that the other health benefit plan lacks sufficient health care delivery resources to assure that health care services will be available and accessible to all of the group enrollees of the insolvent health maintenance organization, the commissioner shall allocate equitably the insolvent health maintenance organization's group contracts for those groups among all health maintenance organizations which operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which a group is so allocated shall offer the group the health maintenance organization's existing coverage which is most similar to the group's coverage with the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology.

(c) The commissioner shall equitably allocate the insolvent health maintenance organization's nongroup enrollees who are unable to obtain other coverage, among all health maintenance organizations which operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which nongroup enrollees are allocated shall

offer the nongroup enrollees the health maintenance organization's existing coverage for individual or conversion coverage as determined by the enrollee's type of coverage in the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology. Successor health maintenance organizations which do not offer direct nongroup enrollment may aggregate all of the allocated nongroup enrollees into one (1) group for rating and coverage purposes.

(d) Any carrier providing replacement coverage with respect to group hospital, medical or surgical expense or service benefits within a period of sixty (60) days from the date of discontinuance of a prior health maintenance organization contract or policy providing the hospital, medical or surgical expense or service benefits shall immediately cover all enrollees who were validly covered under the previous health maintenance organization contract or policy at the date of discontinuance and who would otherwise be eligible for coverage under the succeeding carrier's contract, regardless of any provisions of the contract relating to active employment or hospital confinement or pregnancy.

(e) Except to the extent benefits for the condition would have been reduced or excluded under the prior carrier's contract or policy, no provision in a succeeding carrier's contract of replacement coverage which would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preexisted the effective date of the succeeding carrier's contract shall be applied with respect to those enrollees validly covered under the prior carrier's contract or policy on the date of discontinuance.

26-34-117. Prohibited practices.

(a) No health maintenance organization, or representative thereof, shall 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 purposes of this chapter:

(i) A statement or item of information is:

(A) 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 with a health maintenance organization;

(B) 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, as indicating 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 maintenance organization if the benefit or advantage or absence of limitation, exclusion or disadvantage does not in fact exist.

(ii) 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, is such as to cause a reasonable person, not possessing special knowledge regarding health maintenance organizations and evidences of coverage therefor, to expect benefits, services, premiums or other advantages which the evidence of coverage does not provide or which the health maintenance organization issuing the evidence of coverage does not regularly make available for enrollees covered under the evidence of coverage.

(b) Chapter 13 of this code applies to health maintenance organizations and evidences of coverage except to the extent that the commissioner determines that the nature of health maintenance organizations and evidences of coverage render that chapter, or any section thereof, clearly inappropriate.

(c) A health maintenance organization shall not cancel or refuse to review an enrollee, except for reasons stated in the organization's rules applicable to all enrollees or for the failure to pay the premiums for coverage, or for any other reasons the commissioner may specify by rule and regulation.

(d) No health maintenance organization unless licensed as an insurer shall refer to itself as an insurer or use a name deceptively similar to the name or description of any insurance or surety corporation doing business in the state.

(e) Any person not in possession of a valid certificate of authority issued pursuant to this chapter shall not use the phrase "health maintenance organization" or "HMO" in the course of operation.

(f) A health care maintenance organization shall not refuse to contract with or compensate for covered services an otherwise eligible health care provider solely because that provider has in good faith communicated with one (1) or more of his current, former or prospective patients regarding the provisions, terms or requirements of the organization's products as they related to the needs of that provider's patients.

(g) A health care maintenance organization shall not prohibit or restrict any health care provider from disclosing to any subscriber, enrollee or member any medically appropriate health care information the provider deems appropriate regarding the:

(i) Nature of treatment, risks or alternatives;

(ii) Decision of any plan to authorize or deny services;

(iii) Process used to authorize or deny health care services or benefits.

26-34-118. Regulation of health maintenance organization producers.

(a) The commissioner, after notice and hearing, may promulgate reasonable rules and regulations as necessary to provide for the licensing of health maintenance organization producers. The rules shall establish:

(i) The requirements for licensure of resident health maintenance organization producers;

(ii) The conditions for entering into reciprocal agreements with other jurisdictions for the licensure of nonresident health maintenance organization producers;

(iii) Any examination, prelicensing or continuing education requirements;

(iv) The requirements for registering and terminating the appointment of health maintenance organization producers;

(v) Any requirements for registering any assumed names or office locations in which a health maintenance organization producer does business;

(vi) The conditions for health maintenance organization producer license renewal;

(vii) The grounds for denial, refusal, suspension or revocation of a health maintenance organization producer's license;

(viii) Any required fees for the licensing activities of health maintenance organization producers; and

(ix) Any other requirement or procedure and any form reasonably necessary to provide for the effective administration of the licensing of health maintenance organization producers under this section.

(b) None of the following shall be required to hold a health maintenance organization producer license:

(i) Any regular salaried officer or employee of a health maintenance organization who devotes substantially all of his time to activities other than the taking or transmitting of applications or membership fees or premiums for health maintenance organization membership, or who receives no commission or other compensation directly dependent upon the business obtained and who does not solicit or accept from the public applications for health maintenance organization membership;

(ii) Employers or their officers or employees or the trustees of any employee benefit plan to the extent that the employers, officers, employees or trustees are engaged in the administration or operation of any program of employee benefits involving the use of health maintenance organization memberships, provided that the employers, officers, employees or trustees are not in any manner compensated directly or indirectly by the health maintenance organization issuing the health maintenance organization memberships;

(iii) Banks or their officers and employees to the extent that the banks, officers and employees collect and remit premiums by charging the same against accounts of depositors on the orders of the depositors; or

(iv) Any person or the employee of any person who has contracted to provide administrative, management or health care services to a health maintenance organization and who is compensated for those services by the payment of an amount

calculated as a percentage of the revenues, net income or profit of the health maintenance organization, if that method of compensation is the sole basis for subjecting that person or the employee of the person to this act.

(c) The commissioner, by rule, may exempt certain classes of persons from the requirement of obtaining a license if:

(i) The functions they perform do not require special competence, trustworthiness or the regulatory surveillance made possible by licensing; or

(ii) Other existing safeguards make regulation unnecessary.

26-34-119. Powers of insurers and hospital and health service corporations.

(a) Any insurance company licensed in this state, or a hospital or health service corporation authorized to do business in this state, either directly or through a subsidiary or affiliate, may organize and operate a health maintenance organization under this chapter. Notwithstanding any other law to the contrary, any two (2) or more such insurance companies, hospitals or 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.

(b) Notwithstanding any other provision of this code, any insurer or any hospital or 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 coverage in the event of the failure of the health maintenance organization to meet its obligations.

(c) The enrollees of a health maintenance organization constitute a permissible group under this code or any other laws of this state. Among other things, under any contract specified the insurer or hospital or health service corporation may make benefit payments to health maintenance organizations for health care services rendered by providers.

26-34-120. Examination.

(a) The commissioner may make an examination of the affairs of any health maintenance organization and providers with whom that organization has contracts, agreements or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this state but not less frequently than once every five (5) years.

(b) The administrator may make an examination concerning the quality of health care service and the adequacy of quality assurance programs of any health maintenance organization and providers with whom that organization has contracts, agreements or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this state but not less frequently than once every five (5) years.

(c) Each health maintenance organization and provider shall submit its relevant books and records for the examinations specified in this section and in every way facilitate those examinations. For the purpose of examinations, the commissioner and the administrator may administer oaths to and examine the officers and agents of the health maintenance organization and the principals of any providers concerning their business.

(d) Repealed by Laws 1995, ch. 210, § 3.

(e) Instead of the examinations under this section the commissioner or administrator may accept the report of an examination made by the insurance commissioner or public health commissioner of another state. A report from another state's insurance commissioner shall only be accepted if:

(i) The insurance department preparing the report was, at the time of the examination, accredited under the National Association of Insurance Commissioners' financial regulation standards and accreditation program; or

(ii) The examination is performed under the supervision of an accredited insurance department or with the participation of one (1) or more examiners who are employed by an accredited insurance department and who, after the review of the examination work papers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by their insurance department.

26-34-121. Suspension or revocation of certificate of authority.

(a) The commissioner may suspend or revoke any certificate of authority issued to a health maintenance organization under this chapter if:

(i) The commissioner finds the health maintenance organization:

(A) Is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in any other information submitted under W.S. 26-34-103, unless amendments to those submissions have been filed with and approved by the commissioner;

(B) Issues evidence of coverage or uses a schedule of premiums for health care services which do not comply with W.S. 26-34-109;

(C) Does not provide or arrange for basic or nonbasic health care services;

(D) Is no longer financially responsible and is reasonably expected to be unable to meet its obligations to enrollees or prospective enrollees;

(E) Has failed to correct, within the time prescribed by subsection (c) of this section, any deficiency occurring due to the health maintenance organization's prescribed minimum net worth being impaired;

(F) Has failed to implement the complaint system required by W.S. 26-34-112 in a reasonable manner to resolve valid complaints;

(G) Any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner; or

(H) Has otherwise failed substantially to comply with this chapter.

(ii) The administrator certifies to the commissioner that the health maintenance organization either does not meet the requirements of W.S. 26-34-104(b) or is unable to fulfill its obligations to furnish health care services;

(iii) The commissioner finds the continued operation of the health maintenance organization would be hazardous to its enrollees. The commissioner may consider the factors specified in W.S. 26-3-116(c) and 26-3-132(a) when making this finding.

(b) In addition to or in lieu of suspension or revocation of a certificate of authority pursuant to this section, the applicant or health maintenance organization may be subjected to an administrative penalty of up to ten thousand dollars ($10,000.00) for each cause for suspension or revocation.

(c) Whenever the commissioner finds that the net worth maintained by any health maintenance organization subject to the provisions of this act is less than the minimum net worth required to be maintained by W.S. 26-34-114, he shall give written notice to the health maintenance organization of the amount of the deficiency and require:

(i) Filing with the commissioner a plan for correction of the deficiency acceptable to the commissioner; and

(ii) Correction of the deficiency within a reasonable time, not to exceed sixty (60) days, unless an extension of time, not to exceed sixty (60) additional days, is granted by the commissioner.

(d) A deficiency shall be deemed an impairment, and failure to correct the impairment in the prescribed time shall be grounds for suspension or revocation of the certificate of authority or for placing the health maintenance organization in conservation, rehabilitation or liquidation.

(e) Unless allowed by the commissioner, no health maintenance organization or person acting on its behalf may, directly or indirectly, renew, issue or deliver any certificate, agreement or contract of coverage in this state, for which a premium is charged or collected, when the health maintenance organization writing the coverage is impaired, and the impairment is known to the health maintenance organization or to the person. However, the existence of an impairment shall not prevent the issuance or renewal of a certificate, agreement or contract when the enrollee exercises an option granted under the plan to obtain a new, renewed or converted coverage.

(f) A certificate of authority shall be suspended or revoked, or an administrative penalty levied pursuant to

subsection (b) of this section, only after compliance with W.S. 26-34-125.

(g) If the certificate of authority of a health maintenance organization is suspended, the health maintenance organization, during the period of suspension, shall not enroll any additional enrollees except newborn children or other newly acquired dependents of existing enrollees, and shall not engage in any advertising or solicitation of any kind.

(h) If the certificate of authority of a health maintenance organization is revoked, that organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of its affairs. It shall engage in no further advertising or solicitation of any kind. The commissioner, by written order, may permit any further operation of the organization as he finds to be in the best interest of enrollees, to the end that enrollees are afforded the greatest practical opportunity to obtain continuing health care coverage.

26-34-122. Rehabilitation, liquidation or conservation of a health maintenance organization.

(a) Any rehabilitation, liquidation or conservation of a health maintenance organization is deemed to be the rehabilitation, liquidation or conservation of an insurance company and shall be conducted under the commissioner's supervision pursuant to the provisions of this code governing the rehabilitation, liquidation or conservation of insurance companies. The commissioner may apply for an order directing him to rehabilitate, liquidate or conserve a health maintenance organization upon any one (1) or more grounds set out in chapter 28 of this code, or if in his opinion the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the people of this state. Enrollees have the same priority in the event of liquidation or rehabilitation as the law provides to policyholders of an insurer.

(b) For purposes of determining the priority of distribution of general assets, claims of enrollees and enrollees' beneficiaries shall have the same priority as established by chapter 28 of this code for policyholders and beneficiaries of insureds of insurance companies. If an enrollee is liable to any provider for services provided pursuant to and

covered by the health care plan, that liability shall have the status of an enrollee claim for distribution of general assets.

(c) Any provider who is obligated by statute or agreement to hold enrollees harmless from liability for services provided pursuant to and covered by a health care plan shall have a priority of distribution of the general assets immediately following that of enrollees and enrollees' beneficiaries as described herein, and immediately preceding the priority of distribution described in W.S. 26-28-125(a)(iv).

26-34-123. Summary orders and supervision.

(a) Whenever the commissioner determines that the financial condition of any health maintenance organization is such that its continued operation might be hazardous to its enrollees, creditors, or the general public, or that it has violated any provision of this act, he may, after notice and hearing, order the health maintenance organization to take action reasonably necessary to rectify the condition or violation, including but not limited to one (1) or more of the following:

(i) Reduce the total amount of present and potential liability for benefits by reinsurance or other method acceptable to the commissioner;

(ii) Reduce the volume of new business being accepted;

(iii) Reduce expenses by specified methods;

(iv) Suspend or limit the writing of new business for a period of time;

(v) Increase the health maintenance organization's capital and surplus by contribution; or

(vi) Take other steps the commissioner deems appropriate under the circumstances, including those steps authorized in W.S. 26-3-132(b) and (c) for insurers.

(b) For purposes of this section, the violation by a health maintenance organization of any law of this state to which the health maintenance organization is subject shall be deemed a violation of this act.

(c) The commissioner is authorized, by rules and regulations, to set uniform standards and criteria for early warning that the continued operation of any health maintenance organization might be hazardous to its enrollees, creditors or the general public and to set standards for evaluating the financial condition of any health maintenance organization. The standards shall be consistent with the purposes expressed in subsection (a) of this section.

(d) The remedies and measures available to the commissioner under this section shall be in addition to, and not in lieu of, the remedies and measures available to the commissioner under the provisions of chapter 28 of this code.

26-34-124. Regulations.

The commissioner, after notice and hearing, may promulgate reasonable rules and regulations necessary or proper to carry out this chapter. The rules and regulations are subject to review in accordance with W.S. 28-9-101 through 28-9-108.

26-34-125. Administrative procedures.

(a) If 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 or for the imposition of an administrative penalty exist, he shall notify the health maintenance organization and the administrator by written order specifically stating the grounds for denial, suspension, revocation or administrative penalty. The health maintenance organization or applicant may in writing request a hearing within thirty (30) days from the date of mailing of the order. If no written request is made, the order shall be final upon the expiration of the thirty (30) days.

(b) If the health maintenance organization or applicant requests a hearing pursuant to this section, the commissioner shall issue a written notice of hearing and send it to the health maintenance organization or applicant by certified or registered mail and to the administrator stating:

(i) A specific time for the hearing, which may not be less than twenty (20) nor more than thirty (30) days after mailing of the notice of hearing; and

(ii) A specific place for the hearing, which may be either in Cheyenne or in the county where the health maintenance organization's or applicant's principal place of business is located.

(c) If a hearing is requested, the administrator, or his designated representative, shall be in attendance at the hearing and shall participate in the proceedings. The administrator's recommendations and findings 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 shall be mailed to the health maintenance organization with a copy thereof to the administrator. The commissioner's action and the administrator's recommendations and findings are subject to review by the district court. The court, in disposing of the issue before it, may modify, affirm or reverse the commissioner's order in whole or in part.

(d) The Wyoming Administrative Procedure Act applies to proceedings under this section to the extent it is not in conflict with this section.

26-34-126. Fees; taxes.

(a) Each health maintenance organization subject to this chapter shall pay to the commissioner the following fees:

(i) For filing an application for a certificate of authority or amendment thereto, seven hundred fifty dollars ($750.00);

(ii) For annual certificate of authority renewal, five hundred dollars ($500.00);

(iii) For filing an amendment to the organization documents that requires approval, ten dollars ($10.00) for each document;

(iv) Repealed By Laws 2000, Ch. 30, § 2.

(b) Fees charged under this section shall be paid to the state treasurer for deposit in the general fund.

(c) Each health maintenance organization shall be treated as an authorized insurer for purposes of W.S. 26-2-204.

(d) Each health maintenance organization shall report direct premium income and shall pay premium taxes in accordance with the provisions of chapter 4 of this code.

(e) Each health maintenance organization shall be treated as a member insurer for purposes of the Wyoming Life and Health Insurance Guaranty Association Act.

26-34-127. Penalties and enforcement.

(a) The commissioner, instead of suspension or revocation of a certificate of authority under W.S. 26-34-121, may levy an administrative penalty in an amount not less than one thousand dollars ($1,000.00) nor more than ten thousand dollars ($10,000.00) if reasonable notice in writing 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. The commissioner may augment this penalty by an amount equal to the sum that he calculates to be the damages suffered by enrollees or other members of the public.

(b) If the commissioner or the administrator for any reason has cause to believe that any violation of this chapter has occurred or is threatened, the commissioner or administrator may give notice to the health maintenance organization and to the representatives, or other persons who appear to be involved in the suspected violation, to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to the suspected violation, and, if it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing the violation. Proceedings under this subsection shall not be governed by any formal procedural requirements, and may be conducted in a manner the commissioner or the administrator deems appropriate under the circumstances. However, unless consented to by the health maintenance organization, no rule or order shall result from a conference until the requirements of this section or W.S. 26-34-125 are satisfied.

(c) The commissioner may issue an order directing a health maintenance organization or a representative of a health maintenance organization to cease and desist from engaging in

any act or practice in violation of this chapter. Within fifteen (15) days after service of the cease and desist order, the respondent may request a hearing on the question of whether acts or practices in violation of this chapter have occurred. The hearing shall be conducted pursuant to the Wyoming Administrative Procedure Act, and judicial review is available as provided by that act.

(d) In the case of any violation of this chapter, if the commissioner elects not to issue a cease and desist order, or in case of noncompliance with a cease and desist order issued pursuant to subsection (c) of this section, the commissioner may institute a proceeding to obtain injunctive or other appropriate relief in the district court.

(e) Notwithstanding any other provisions of this act, if a health maintenance organization fails to comply with the net worth requirement of this act, the commissioner is authorized to take appropriate action to assure that the continued operation of the health maintenance organization will not be hazardous to its enrollees.

26-34-128. Statutory construction and relationship to other laws.

(a) Except as otherwise specifically provided in this chapter, the other provisions of this code relating to insurers and the provisions of title 35 of the Wyoming statutes relating to hospitals or medical service corporations are not applicable to any health maintenance organization granted a certificate of authority under this chapter. This provision does not apply to:

(i) An insurer or hospital or medical service corporation licensed and regulated pursuant to the insurance law or the hospital or medical service corporation laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to this chapter.

(ii) Repealed By Laws 2004, ch. 130, § 2.

(b) Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

(c) Any health maintenance organization authorized under this chapter is not deemed to be practicing medicine and is exempt from the provisions of W.S. 33-26-101 through 33-26-511.

26-34-129. Filings and reports as public documents.

All applications, filings and reports required under this chapter, except those which are trade secrets or privileged or confidential quality assurance, commercial or financial information, other than any annual financial statement that may be required under W.S. 26-34-110, shall be treated as public documents.

26-34-130. Confidentiality of medical information.

(a) Any data or information pertaining to the diagnosis, treatment or health of any enrollee or applicant obtained from that person or from any provider by any health maintenance organization shall be held in confidence and shall not be disclosed to any person except:

(i) To the extent that it may be necessary to carry out the purposes of this chapter;

(ii) Upon the express consent of the enrollee or applicant;

(iii) Pursuant to statute or court order for the production of evidence or the discovery thereof; or

(iv) In case of claim or litigation between the person and the health maintenance organization wherein the data or information is pertinent.

(b) A health maintenance organization is entitled to claim any statutory privileges against such disclosure which the provider who furnished the information to the health maintenance organization is entitled to claim.

(c) A person who, in good faith and without malice, takes any action or makes any decision or recommendation as a member, agent or employee of a health care review committee or who furnishes any records, information or assistance to such a committee shall not be subject to liability for civil damages or any legal action in consequence of that action, nor shall the health maintenance organization which established such a committee or the officers, directors, employees or agents of the

health maintenance organization be liable for the activities of any such person. This section shall not be construed to relieve any person of liability arising from treatment of a patient.

(d) The information considered by a health care review committee and the records of its actions and proceedings shall be confidential and not subject to subpoena or order to produce except in proceedings before the appropriate state licensing or certifying agency, or in an appeal, if permitted, from the committee's findings or recommendations. The information shall not be shared pursuant to W.S. 26-2-113(d). No member of a health care review committee, or officer, director or other member of a health maintenance organization or its staff engaged in assisting such committee, or any person assisting or furnishing information to such committee may be subpoenaed to testify in any judicial or quasi-judicial proceeding if the subpoena is based solely on such activities. Information considered by a health care review committee and the records of its actions and proceedings which are used pursuant to this subsection by a state licensing or certifying agency or in an appeal shall be kept confidential and shall be subject to the same provision concerning discovery and use in legal actions as are the original information and records in the possession and control of a health care review committee.

(e) To fulfill its obligations under W.S. 26-34-108, the health maintenance organization shall have access to treatment records and other information pertaining to the diagnosis, treatment or health status of any enrollee.

26-34-131. Administrator's authority to contract.

The administrator, in carrying out his obligations under this chapter may contract with qualified persons to make recommendations concerning the determinations he is required to make. The administrator may accept the recommendations in full or in part.

26-34-132. Acquisition of control of or merger of a health maintenance organization.

No person may make a tender for or a request or invitation for tenders of, or enter into an agreement to exchange securities for or acquire in the open market or otherwise, any voting security of a health maintenance organization, or enter into any other agreement if, after the consummation thereof, that person would, directly or indirectly, or by conversion or by exercise

of any right to acquire, be in control of the health maintenance organization, and no person may enter into an agreement to merge or consolidate with or otherwise to acquire control of a health maintenance organization, unless, at the time any offer, request or invitation is made or any 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 health maintenance organization, information required by W.S. 26-44-103(b)(i) through (v), (c) and (d) and the offer, request, invitation, agreement or acquisition has been approved by the commissioner. Approval by the commissioner shall be governed by W.S. 26-44-103(f) through (h).

26-34-133. Coordination of benefits.

(a) Health maintenance organizations are permitted, but not required, to adopt coordination of benefits provisions to avoid overinsurance and to provide for the orderly payment of claims when a person is covered by two (2) or more group health insurance or health care plans.

(b) If a health maintenance organization adopts coordination of benefits provisions, the provisions shall be consistent with the coordination of benefits provisions that are in general use in the state for coordinating coverage between two (2) or more group health insurance or health care plans.

(c) To the extent necessary for health maintenance organizations to meet their obligations as secondary carriers under the rules for coordination, the organizations shall make payments for services that are:

(i) Received from nonparticipating providers; or

(ii) Provided outside their service areas.

26-34-134. Written agreement with providers; discrimination prohibited.

(a) Before entering into any written agreement with any provider for the furnishing of health care services to enrollees of a health maintenance organization the organization shall establish terms and conditions to be required of any provider interested in entering into the agreement. In no event shall any Wyoming provider willing to meet the established terms and conditions be denied the right to enter into any written agreement. The established terms and conditions shall not

discriminate against any Wyoming provider solely on the basis of an inability to provide specified services within a health maintenance organization's entire service area. This subsection shall not be construed to require any health maintenance organization to involuntarily employ any person, sell any ownership interest to any person, enter into any partnership with any person or grant staff privileges to any person.

(b) No health maintenance organization shall discriminate in employment, contracting, participation, reimbursement or indemnification against a provider who is acting within the scope of his professional license under applicable state law, based solely on the academic degree of the provider.

26-34-135. Application of other laws.

(a) The annual audited financial reports law, title 26, chapter 3, article 3 of the Wyoming statutes, shall apply to domestic health maintenance organizations licensed under this chapter.

(b) The Wyoming Insurance Holding Company System Regulatory Act, title 26, chapter 44 of the Wyoming statutes, shall apply to domestic health maintenance organizations licensed under this chapter.

(c) Except for those portions of the Wyoming Insurance Holding Company System Regulatory Act, title 26, chapter 44 of the Wyoming statutes, made applicable by W.S. 26-34-132 and which are in effect prior to January 1, 2017, this section shall be applied to domestic health maintenance organizations licensed under this chapter on and after January 1, 2017.

(d) The Wyoming Insurance Corporate Governance Annual Disclosure Act, W.S. 26-54-101 through 26-54-108, shall apply to domestic health maintenance organizations licensed under this chapter.

CHAPTER 35 - CANCELLATION, RENEWAL AND NONRENEWAL OF POLICIES

ARTICLE 1 - IN GENERAL

26-35-101. Manner of providing notice.

Notices required by this chapter shall be personally delivered to the insured and the agent or shall be mailed to the insured and the agent at their addresses last of record with the

insurer. If mailed, notice shall be deemed given when deposited in the United States mail, postage prepaid. Proof of mailing shall be sufficient proof of notice.

26-35-102. Refund of unearned premium upon cancellation.

Any insurer who cancels a policy of insurance in accordance with this chapter shall, prior to cancellation, refund any unearned premium to the policyholder.

26-35-103. Prohibited practices.

(a) It is unlawful for any insurer to cancel, nonrenew or renew a policy of insurance except in compliance with the requirements of this chapter.

(b) Mid-term cancellation of an entire block, line or class of business is presumed to be unfair, inequitable, deceptive, contrary to the public interest or a method and practice rendering the further transaction of insurance in this state injurious to policyholders or to the public and is hereby declared to be unlawful.

(c) If a policy has been issued for a term longer than one (1) year, and for additional premium consideration an annual premium has been guaranteed, it shall be unlawful for the insurer to increase that annual premium during the term of that policy.

26-35-104. Penalties.

Any insurer who violates this chapter is subject to monetary penalties or license revocation or suspension as provided in W.S. 26-1-107 and 26-3-116.

26-35-105. Issuance or renewal with exclusions.

An insurer may in lieu of nonissuance, cancellation, nonrenewal or premium increase offer to issue, continue or renew a motor vehicle insurance policy but to exclude from coverage, by name, the person whose claim experience or driving record would have justified the nonissuance, premium increase, cancellation or nonrenewal.

26-35-106. Transfers of policies resulting from mergers, acquisitions or restructuring or resulting in broader coverage; notice not required.

(a) Subject to the provisions of W.S. 26-35-204, a nonrenewal or cancellation notice shall not be required if a policy is transferred from an insurer to an affiliated insurer under common management and control:

(i) As a result of a merger, acquisition or company restructuring; or

(ii) If the transfer results in the same or broader coverage.

(b) Nothing in this section shall be construed as limiting the right of an insured to cancel a policy.

ARTICLE 2 - PROPERTY AND CASUALTY INSURANCE POLICIES

26-35-201. Scope of article.

This article applies to all property and casualty insurance as defined in W.S. 26-5-104 and 26-5-106, except this article does not apply to binders and other temporary contracts for temporary insurance.

26-35-202. Mid-term cancellation; grounds; notice; exception.

(a) An insurance policy or renewal shall not be cancelled by an insurer prior to the expiration of the term stated in the policy, except for any one (1) of the following reasons:

(i) Failure to pay a premium when due;

(ii) Material misrepresentation of fact which if known to the company would have caused the company not to issue the policy;

(iii) Substantial change in the risk assumed, except to the extent that the insurer should reasonably have foreseen the change or contemplated the risk in writing the policy; or

(iv) Substantial breaches of contractual duties, conditions or warranties.

(b) Cancellation under paragraph (a)(i), (iii) or (iv) of this section shall not be effective unless written notice

stating the precise reason for cancellation has been made as provided in W.S. 26-35-101:

(i) Not less than ten (10) days prior to the proposed effective date of cancellation if cancellation is for the reason stated in paragraph (a)(i) of this section; or

(ii) Not less than forty-five (45) days prior to the proposed effective date of cancellation in all other cases except paragraph (a)(ii) of this section.

(c) Subsections (a) and (b) of this section do not apply to any insurance policy which has been in effect for less than sixty (60) days and is not a renewal of a previously existing policy for a term longer than sixty (60) days.

(d) If an insurance company loses its reinsurance and the loss threatens the solvency of the company, the company shall:

(i) Continue coverage to the extent of its retention as to each policyholder;

(ii) Notify each policyholder of the amount of coverage still present; and

(iii) Refund the unearned premium.

26-35-203. Nonrenewal; notice.

(a) No insurance policy shall be nonrenewed by an insurer except in accordance with the provisions of this section and any nonrenewal attempted which is not in compliance with this section is ineffective.

(b) A policy may be nonrenewed by the insurer at its expiration or anniversary date by giving written notice of nonrenewal as provided in W.S. 26-35-101, not less than forty-five (45) days, or if the policy is a professional health care malpractice liability policy not less than ninety (90) days, prior to the expiration or anniversary date of the policy.

(c) Any notice of nonrenewal under this section shall state the precise reason for nonrenewal. There shall be no liability on the part of an insurer for stated reasons of nonrenewal given in good faith pursuant to this article.

26-35-204. Renewal with altered terms; notice.

(a) If an insurer intends to renew a policy, but on less favorable terms or at higher rates, the insurer shall furnish to the insured and the agent of record, if any, renewal terms and a statement of the amount of premium due for the renewal policy period in accordance with this section.

(b) The renewal terms and statement of premium due shall be given pursuant to W.S. 26-35-101 not less than forty-five (45) days, or if the policy is a professional health care malpractice liability policy not less than ninety (90) days, prior to the expiration or anniversary date of the original policy. For rates regulated pursuant to W.S. 26-14-106(a) and (b), sixty (60) days notice of the renewal terms and premium due shall be required if the insurer notified the insured of its proposed changes at the time the insurer filed with the insurance commissioner.

(c) If the insurer fails to furnish the renewal terms and statement of premium due in the manner required by this section, the insured may elect to cancel the renewal policy within the forty-five (45) day period following receipt of the renewal terms and statement of premium due. Earned premium for any period of coverage shall be calculated pro rata based upon the premium applicable to the original policy and not the premium applicable to the renewal policy.

CHAPTER 36 - RISK RETENTION

26-36-101. Short title.

This chapter may be cited as the "Risk Retention Act".

26-36-102. Purpose.

The purpose of this act is to regulate the formation and operation of risk retention groups in this state formed pursuant to the provisions of the federal Liability Risk Retention Act of 1986.

26-36-103. Definitions.

(a) As used in this act:

(i) "Commissioner" means the commissioner of insurance of this state or the commissioner, director or superintendent of insurance in any other state;

(ii) "Completed operations liability" means liability arising out of the installation, maintenance or repair of any product at a site which is not owned or controlled by any person who performs that work, or any person who hires an independent contractor to perform that work, but includes liability for activities which are completed or abandoned before the date of the occurrence giving rise to the liability;

(iii) "Domicile" for purposes of determining the state in which a purchasing group is domiciled, means:

(A) For a corporation, the state in which the purchasing group is incorporated; and

(B) For an unincorporated entity, the state of its principal place of business.

(iv) "Hazardous financial condition" means that, based on its present or reasonably anticipated financial condition, a risk retention group, although not yet financially impaired or insolvent, is unlikely to be able:

(A) To meet obligations to policyholders with respect to known claims and reasonably anticipated claims; or

(B) To pay other obligations in the normal course of business.

(v) "Insurance" means primary insurance, excess insurance, reinsurance, surplus lines insurance and any other arrangement for shifting and distributing risk which is determined to be insurance under the laws of this state;

(vi) "Liability" as used in the act means legal liability for damages including costs of defense, legal costs and fees, and other claims or expenses because of injuries to other persons, damage to their property, or other damage or loss to such other persons resulting from or arising out of any business whether profit or nonprofit, trade, product, services including professional services, premises or operations, or any activity of any state or local government, or any agency or political subdivision thereof except, the term does not include personal risk liability or an employer's liability with respect to its employees other than legal liability under the Federal Employers' Liability Act (45 U.S.C. § 51 et seq.);

(vii) "Personal risk liability" means liability for damages because of injury to any person, damage to property or other loss or damage resulting from any personal, familial or household responsibilities or activities, rather than from responsibilities or activities referred to in subsection (vi) of this section;

(viii) "Plan of operation or a feasibility study" means an analysis which presents the expected activities and results of a risk retention group including, at a minimum:

(A) The coverages, deductibles, coverage limits, rates and rating classification systems for each line of insurance the group intends to offer;

(B) Historical and expected loss experience of the proposed members and national experience of similar exposures to the extent that this experience is reasonably available;

(C) Pro forma financial statements and projections;

(D) Appropriate opinions by a qualified, independent casualty actuary, including a determination of minimum premium or participation levels required to commence operations and to prevent a hazardous financial condition;

(E) Identification of management, underwriting procedures, managerial oversight methods and investment policies; and

(F) Such other matters as may be prescribed by the commissioner for liability insurance companies authorized by the insurance laws of the state in which the risk retention group is chartered.

(ix) "Product liability" means liability for damages because of any personal injury, death, emotional harm, consequential economic damage or property damage including damages resulting from the loss of use of property arising out of the manufacture, design, importation, distribution, packaging, labeling, lease or sale of a product, but does not include the liability of any person for those damages if the product involved was in the possession of such a person when the incident giving rise to the claim occurred;

(x) "Purchasing group" means any group which:

(A) Has as one (1) of its purposes the purchase of liability insurance on a group basis;

(B) Purchases such insurance only for its group members and only to cover their similar or related liability exposure, as described in subparagraph (C) of this paragraph;

(C) Is composed of members whose businesses or activities are similar or related with respect to the liability to which members are exposed by virtue of any related, similar or common business, trade, product, services, premises or operations; and

(D) Is domiciled in any state.

(xi) "Risk retention group" means any corporation or other limited liability association formed under the laws of any state, Bermuda or the Cayman Islands:

(A) Whose primary activity consists of assuming and spreading all or any portion of the liability exposure of its group members;

(B) Which is organized for the primary purpose of conducting the activity described under subparagraph (A) of this paragraph;

(C) Which is chartered and licensed as a liability insurance company and authorized to engage in the business of insurance under the laws of any state, or before January 1, 1985 was chartered or licensed and authorized to engage in the business of insurance under the laws of Bermuda or the Cayman Islands and, before such date, had certified to the insurance commissioner of at least one (1) state that it satisfied the capitalization requirements of such state, except that any such group shall be considered to be a risk retention group only if it has been engaged in business continuously since such date and only for the purpose of continuing to provide insurance to cover product liability or completed operations liability as such terms were defined in the Product Liability Risk Retention Act of 1981 before the date of the enactment of the Liability Risk Retention Act of 1986;

(D) Which does not exclude any person from membership in the group solely to provide for members of such a group a competitive advantage over such a person;

(E) Which has as its members only persons who have an ownership interest in the group and which has as its owners only persons who are members who are provided insurance by the risk retention group, or has as its sole member and sole owner an organization which is owned by persons who are provided insurance by the risk retention group;

(F) Whose members are engaged in businesses or activities similar or related to the liability of which such members are exposed by virtue of any related, similar or common business trade, product, services, premises or operations;

(G) Whose activities do not include the provision of insurance other than liability insurance for assuming and spreading all or any portion of the liability of its group members and reinsurance with respect to the liability of any other risk retention group or any members of such other group which is engaged in businesses or activities so that such group or member meets the requirement described in subparagraph (F) of this paragraph from membership in the risk retention group which provides such reinsurance;

(H) The name of which includes the phrase "Risk Retention Group".

(xii) "State" means any state of the United States or the District of Columbia;

(xiii) "This act" means W.S. 26-36-101 through 26-36-116.

26-36-104. Risk retention groups chartered in this state.

A risk retention group seeking to be chartered in this state must be chartered and licensed as a liability insurance company authorized by the insurance laws of this state and, except as provided elsewhere in this act, must comply with all of the laws, rules, regulations and requirements applicable to such insurers chartered and licensed in this state and with W.S. 26-36-106 to the extent such requirements are not a limitation on laws, rules, regulations or requirements of this state. Before it may offer insurance in any state, each risk retention group shall also submit for approval to the insurance

commissioner of this state a plan of operation or a feasibility study and revisions of such plan or study if the group intends to offer any additional lines of liability insurance. Immediately upon receipt of an application for charter, this state shall provide summary information concerning the filing to the National Association of Insurance Commissioners, including the name of the risk retention group, the identity of the initial members of the group, the identity of those individuals who organized the group or who will provide administrative services or otherwise influence or control the activities of the group, the amount and nature of initial capitalization, the coverages to be afforded and the states in which the group intends to operate. Providing notification to the National Association of Insurance Commissioners is in addition to and shall not be sufficient to satisfy the requirements of W.S. 26-36-106 and all other sections of this act.

26-36-105. Risk retention groups not chartered in this state.

(a) Risk retention groups chartered in states other than this state and seeking to do business as a risk retention group in this state must observe and abide by the laws of this state.

(b) Before offering insurance in this state, a risk retention group shall submit to the commissioner:

(i) A statement identifying the state or states in which the risk retention group is chartered and licensed as a liability insurance company, date of chartering, its principal place of business and such other information, including information on its membership, as the commissioner of this state may require to verify that the risk retention group is qualified under W.S. 26-36-103(a)(xi);

(ii) A copy of its plan of operations or a feasibility study and revisions of such plan or study submitted to its state of domicile, except that the provision relating to the submission of a plan of operation or a feasibility study shall not apply with respect to any line or classification of liability insurance which:

(A) Was defined in the Product Liability Risk Retention Act of 1981 before October 27, 1986; and

(B) Was offered before such date by any risk retention group which had been chartered and operating for not less than three (3) years before such date.

(iii) A statement of registration which designates the commissioner as its agent for the purpose of receiving service of legal documents or process.

(c) Any risk retention group doing business in this state shall submit the following documentation of financial condition to the commissioner:

(i) A copy of the group's financial statement submitted to its state of domicile, which shall be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or a qualified loss reserve specialist under criteria established by the National Association of Insurance Commissioners;

(ii) A copy of each examination of the risk retention group as certified by the commissioner or public official conducting the examination;

(iii) Upon request by the commissioner, a copy of any audit performed with respect to the risk retention group; and

(iv) Such information as may be required to verify its continuing qualification as a risk retention group under W.S. 26-36-103(a)(xi).

(d) All premiums paid for coverages within this state to risk retention groups shall be subject to taxation at the same rate and subject to the same interest, fines and penalties for nonpayment as that applicable to foreign admitted insurers. To the extent agents or brokers are utilized, they shall report and pay the taxes for the premiums for risks which they have placed with or on behalf of a risk retention group not chartered in this state. To the extent agents or brokers are not utilized or fail to pay the tax, each risk retention group shall pay the tax for risks insured within the state. Further, each risk retention group shall report all premiums paid to it for risks insured within the state.

(e) Any risk retention group, its agents and representatives shall comply with the law governing unfair claims settlement practices, W.S. 26-13-124.

(f) Any risk retention group shall comply with the laws of this state regarding deceptive, false or fraudulent acts or practices. If the commissioner seeks an injunction regarding such conduct, the injunction must be obtained from a court of competent jurisdiction.

(g) Any risk retention group must submit to an examination by the commissioner to determine its financial condition if the commissioner of the jurisdiction in which the group is chartered has not initiated an examination or does not initiate an examination within sixty (60) days after a request by the commissioner of this state. Any such examination shall be coordinated to avoid unjustified repetition and conducted in an expeditious manner and in accordance with the National Association of Insurance Commissioners' Examiner Handbook.

(h) Any policy issued by a risk retention group shall contain in ten point type on the front page and the declaration page, the following notice:

NOTICE

This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group.

(j) The following acts by a risk retention group are hereby prohibited:

(i) The solicitation or sale of insurance by a risk retention group to any person who is not eligible for membership in such group; and

(ii) The solicitation or sale of insurance by, or operation of, a risk retention group that is in a hazardous financial condition or is financially impaired.

(k) No risk retention group shall be allowed to do business in this state if an insurance company is directly or indirectly a member or owner of such risk retention group, other than in the case of a risk retention group all of whose members are insurance companies.

(m) A risk retention group not chartered in this state and doing business in this state must comply with a lawful order

issued in a voluntary dissolution proceeding or in a delinquency proceeding commenced by a state insurance commissioner if there has been a finding of financial impairment after an examination under subsection (g) of this section.

(n) No risk retention group may offer insurance policy coverage prohibited by this code or declared unlawful by the highest court of this state.

26-36-106. Compulsory associations.

(a) No risk retention group shall be permitted to join or contribute financially to any insurance insolvency guaranty fund or similar mechanism in this state, nor shall any risk retention group or its insureds receive any benefit from any such fund for claims arising out of the operations of such risk retention group.

(b) A risk retention group shall participate in this state's joint underwriting associations and mandatory liability pools as provided by this act.

26-36-107. Repealed by Laws 2000, Ch. 19, § 2.

26-36-108. Purchasing groups; exemption from certain laws relating to the group purchase of insurance.

Any purchasing group meeting the criteria established under the provisions of the federal Liability Risk Retention Act of 1986 shall be exempt from any law of this state relating to the creation of groups for the purchase of insurance, prohibition of group purchasing or any law that would discriminate against a purchasing group or its members. In addition, an insurer shall be exempt from any law of this state which prohibits providing, or offering to provide, to a purchasing group or its members advantages based on their loss and expense experience not afforded to other persons with respect to rates, policy forms, coverages or other matters. A purchasing group shall be subject to all other applicable laws of this state.

26-36-109. Notice and registration requirements of purchasing groups.

(a) A purchasing group which intends to do business in this state shall furnish notice to the commissioner which shall:

(i) Identify the state in which the group is domiciled;

(ii) Specify the lines and classifications of liability insurance which the purchasing group intends to purchase;

(iii) Identify the insurance company from which the group intends to purchase its insurance and the domicile of such company;

(iv) Identify the principal place of business of the group; and

(v) Provide such other information as may be required by the commissioner to verify that the purchasing group is qualified under W.S. 26-36-103(a)(x).

(b) The purchasing group shall register with and designate the commissioner as its agent solely for the purpose of receiving service of legal documents or process, except that such requirements shall not apply in the case of a purchasing group:

(i) Which was domiciled before April 1, 1986, and is domiciled on and after October 27, 1986 in any state of the United States;

(ii) Which before October 27, 1986 purchased insurance from an insurance carrier licensed in any state, and since October 27, 1986 purchased its insurance from an insurance carrier licensed in any state;

(iii) Which was a purchasing group under the requirements of the Product Liability Risk Retention Act of 1981 before October 27, 1986; and

(iv) Which does not purchase insurance that was not authorized for purposes of an exemption under that act, as in effect before October 27, 1986.

26-36-110. Restrictions on insurance purchased by purchasing groups.

A purchasing group may not purchase insurance from a risk retention group that is not chartered in a state or from an insurer not admitted in the state in which the purchasing group

is located unless the purchase is effected through a licensed agent or broker acting pursuant to the surplus lines laws and regulations of such state.

26-36-111. Administrative and procedural authority regarding risk retention groups and purchasing groups.

The commissioner is authorized to make use of any of the powers established under the Insurance Code of this state to enforce the laws of this state so long as those powers are not specifically preempted by the Product Liability Risk Retention Act of 1981, as amended by the Risk Retention Amendments of 1986. This includes, but is not limited to, the commissioner's administrative authority to investigate, issue subpoenas, conduct depositions and hearings, issue orders and impose penalties. With regard to any investigation, administrative proceedings or litigation, the commissioner can rely on the procedural law and regulations of the state. The injunctive authority of the commissioner in regard to risk retention groups is restricted by the requirement that any injunction be issued by a court of competent jurisdiction.

26-36-112. Penalties.

A risk retention group which violates any provision of this act will be subject to fines and penalties applicable to licensed insurers generally, including revocation of its license and the right to do business in this state.

26-36-113. Duty of agents or brokers to obtain license.

Any person acting or offering to act as an agent or broker for a risk retention group or purchasing group which solicits members, sells insurance coverage, purchases coverage for its members located within the state or otherwise does business in this state shall, before commencing any such activity, obtain a license from the commissioner pursuant to the laws of this state except that no restrictions as to residency which discriminate against a nonresident agent or broker shall apply to risk retention agents or brokers.

26-36-114. Binding effect of orders issued in United States district court.

An order issued by any district court of the United States enjoining a risk retention group from soliciting or selling insurance or operating in any state or in all states or in any

territory or possession of the United States upon a finding that such a group is in a hazardous financial condition shall be enforceable in the courts of this state.

26-36-115. Rules and regulations.

The commissioner may establish and from time to time amend such rules relating to risk retention groups as may be necessary to implement the provisions of the act.

26-36-116. Registration fee.

Each risk retention group or risk purchasing group seeking to do business in the state of Wyoming shall pay a registration fee of two hundred dollars ($200.00), which shall accompany the required registration application. Each risk retention group or risk purchasing group doing business in Wyoming shall be required to pay an annual fee of two hundred dollars ($200.00) payable on or before March 1 of each year to renew its registration.

CHAPTER 37 - MECHANICAL BREAKDOWN INSURANCE

26-37-101. Short title.

This chapter is known and may be cited as the "Mechanical Breakdown Insurance Act".

26-37-102. Definitions.

(a) As used in this chapter:

(i) "Agent" means a person licensed as a casualty insurance agent in this state and appointed by a mechanical breakdown insurer as its agent under this code;

(ii) "Commissioner" means the state insurance commissioner;

(iii) "Department" means the state department of insurance;

(iv) "Mechanical breakdown insurance" means a contractual undertaking in which a person undertakes to indemnify another for direct or consequential loss caused by the failure or malfunction of a component or system of a motor vehicle, but does not include:

(A) For new motor vehicles, those contractual undertakings to repair the motor vehicle provided by the manufacturer, by a subsidiary of the manufacturer or by the importer only;

(B) For used motor vehicles, those contractual undertakings to repair the motor vehicle provided and administered by the manufacturer, a subsidiary of the manufacturer, the seller or the lessor only;

(C) Service contracts issued by persons pursuant to article 1 of chapter 49 of this code.

(v) "Mechanical breakdown insurance organization" or "organization" means any legal entity transacting mechanical breakdown insurance as an insurer in this state whether directly or indirectly, who is not a "mechanical breakdown insurer" as defined in this chapter;

(vi) "Mechanical breakdown insurance dealer" or "dealer" means a person dealing in or financing the purchase of motor vehicles or an authorized motor club under this code, and transacting mechanical breakdown insurance in this state as a contractor for a mechanical breakdown insurance organization;

(vii) "Mechanical breakdown insurance representative" or "representative" means an individual either the sole proprietor, officer or employee of a dealer and soliciting applications for mechanical breakdown insurance as the representative of that dealer;

(viii) "Mechanical breakdown insurer" means a person holding a subsisting certificate of authority to transact casualty insurance in this state and transacting mechanical breakdown insurance in this state;

(ix) "Motor vehicle" means a self-propelled device or a component of a self-propelled device designed to transport persons or cargo upon land or water or through air;

(x) "This code" means title 26 of the Wyoming statutes.

26-37-103. Authorization required.

Except as otherwise provided in this chapter, no person shall transact mechanical breakdown insurance in this state unless authorized by the commissioner.

26-37-104. Mechanical breakdown insurers; authorization required; application; fee; issuance; renewal; revocation and suspension.

(a) Any person holding a subsisting certificate of authority to transact casualty insurance in this state may apply to the commissioner for authorization to transact mechanical breakdown insurance in this state as a mechanical breakdown insurer.

(b) Application under subsection (a) of this section shall include:

(i) The name and address of the applicant;

(ii) Copies of any subsisting certificates of authority held by the applicant to transact casualty insurance in this state;

(iii) Copies of all policy forms to be used by the applicant;

(iv) A statement delineating the marketing and claims procedures to be used by the applicant along with copies of all relevant forms.

(c) A fee of one hundred dollars ($100.00) shall accompany the application under subsection (b) of this section.

(d) The commissioner shall:

(i) Review the application;

(ii) Notify the applicant of his approval or rejection of the application; and

(iii) Issue a certificate of authority if appropriate.

(e) A certificate of authority is renewable annually unless sooner revoked or suspended.

(f) Mechanical breakdown insurers shall comply with all other provisions of this code relating to the transaction of insurance as an insurer.

(g) The commissioner may revoke or suspend a certificate of authority for any reason enumerated in chapter 3 of this code, following the procedures for hearings in chapter 2 of this code.

26-37-105. Agents of mechanical breakdown insurers.

(a) Upon issuance of a certificate of authority under W.S. 26-37-104, a licensed agent appointed to market the casualty insurance policies of the certified mechanical breakdown insurer within this state may market mechanical breakdown insurance policies of that insurer within this state without further licensing, testing or fees from the department.

(b) Agents marketing mechanical breakdown insurance shall comply with all other provisions of this code relating to the transaction of insurance as an agent.

26-37-106. Mechanical breakdown insurance organizations; applications for certificates of authority; fee; issuance.

(a) A mechanical breakdown insurance organization may file with the commissioner an application for a certificate of authority to transact mechanical breakdown insurance in this state upon a form to be furnished by the department which shall include the following:

(i) The names, addresses and all occupations of any current and anticipated principal, partner, officer and director for the preceding ten (10) years;

(ii) A certified copy of any corporate articles and bylaws, partnership agreements and other organizational agreements reasonably required by the commissioner and if previously incorporated, the corporate annual statements and reports for the three (3) most recent years;

(iii) A statement of the amount and sources of the funds available for organization expenses and the proposed arrangements for reimbursement and compensation of incorporators or other persons;

(iv) A statement of compensation of current and anticipated principals, partners, directors and officers;

(v) The forms to be used for any proposed contracts between the organization and providers of mechanical breakdown services and any corporations which perform administrative, marketing or management services concerning the provision of services to insureds;

(vi) The plan for conducting the insurance business, including the following:

(A) The geographical area in which the business is to be transacted in the first five (5) years;

(B) The types of insurance to be written in the first five (5) years including whether and to what extent repayment rather than service benefits are to be provided;

(C) The proposed marketing methods;

(D) Actuarial data or other similar statistical data, documented and verified in the manner the department may reasonably require, affirmatively demonstrating the anticipated income and expenses in the first five (5) years including without limitation, the projected expenditure for mechanical breakdown services and projected source of funds for any anticipated deficit;

(E) A complete statement concerning claims procedures.

(vii) A current statement of the assets and liabilities of the applicant;

(viii) Forms of all mechanical breakdown insurance contracts the applicant proposes to offer specifying the rates to be charged for each form of contract;

(ix) Any other documents or information the department reasonably requires.

(b) A fee of two hundred fifty dollars ($250.00) shall accompany the application filed under subsection (a) of this section.

(c) The commissioner shall issue a certificate of authority if he is satisfied that:

(i) All requirements of law are met;

(ii) All current and anticipated principals, partners, incorporators, directors and principal officers are trustworthy and competent and collectively have the competence and experience to engage in the proposed insurance business; and

(iii) The business plan is consistent with the interests of the potential insureds of the corporation and the public.

26-37-107. Mechanical breakdown insurance organizations; revocation or suspension of certificate of authority.

(a) The commissioner shall revoke or suspend the certificate of authority issued to any mechanical breakdown insurance organization under W.S. 26-37-106 if after a hearing in accordance with W.S. 26-2-125 through 26-2-129, he finds the organization:

(i) Violates any provision of this chapter or chapter 13 of this code;

(ii) Is insolvent;

(iii) Has assets less than its liabilities;

(iv) Refuses or any officer refuses to submit to an examination; or

(v) Is transacting business fraudulently.

(b) The commissioner shall give public notice of any revocation or suspension under this section in a manner he deems proper.

26-37-108. Mechanical breakdown insurance organizations; bond, deposit or contractual liability insurance requirement; amounts; purpose; release; modification of initial order.

(a) To assure the faithful performance of obligations under insolvency, each mechanical breakdown insurance organization certified under W.S. 26-37-106 shall deposit and maintain with the commissioner, trust securities of the type

eligible as investments by insurers under chapter 7 of this code. The trust securities required by this section shall at all times have the following market value:

(i) For an organization not transacting mechanical breakdown insurance in this state prior to January 1, 1987 and before issuing a certificate of authority under this chapter and receiving premiums, an initial amount of fifty thousand dollars ($50,000.00);

(ii) For an organization transacting mechanical breakdown insurance in this state prior to January 1, 1987 and having in force less than three hundred thousand dollars ($300,000.00) of gross written premiums, membership fees or similar charges, a sum equal to fifty percent (50%) of the gross premiums in force or fifty thousand dollars ($50,000.00), whichever is less;

(iii) For an organization transacting mechanical breakdown insurance in this state prior to January 1, 1987 and having in force more than three hundred thousand dollars ($300,000.00) but less than seven hundred fifty thousand dollars ($750,000.00) of gross written premiums, membership fees or similar charges in this state, an amount not less than seventy-five thousand dollars ($75,000.00); and

(iv) For an organization transacting mechanical breakdown insurance in this state prior to January 1, 1987 and having in force seven hundred fifty thousand dollars ($750,000.00) or more of gross written premiums, membership fees or similar charges in this state, an amount equal to one hundred thousand dollars ($100,000.00).

(b) An organization may instead of depositing securities required under subsection (a) of this section and subject to the approval of the commissioner, file with the commissioner a surety bond issued by an authorized surety insurer under this code. The bond shall be for that purpose stated under subsection (a) of this section and the commissioner shall not approve any bond if the protection against insolvency is not equal to the protection afforded by those securities under subsection (a) of this section.

(c) An organization may instead of any deposit of securities or filing of surety bonds required under subsections (a) and (b) of this section and subject to approval of the commissioner, file a paid contractual liability insurance policy

with the commissioner. This policy shall be issued by an insurer authorized to transact insurance in this state and shall be in an amount equal to or greater than fifty percent (50%) of gross written premiums in this state. The commissioner shall not approve any contractual liability insurance policy if the protection against insolvency is not equal to the protection afforded by those securities under subsection (a) of this section.

(d) Securities, bonds or insurance policies posted or filed pursuant to this section shall in case of insolvency or impairment of any organization, be for the benefit of and subject to action by any person sustaining any injury due to the failure of the organization to faithfully perform its obligations to its insureds.

(e) The state is responsible for the safekeeping of all securities deposited with the commissioner under this chapter. The securities are not subject to taxation but shall be held exclusively to guarantee the performance of the obligations of the organization to its insureds.

(f) The deposit, bond or insurance shall be maintained unimpaired as long as the mechanical breakdown insurance organization continues to operate in this state. If the organization ceases to do business in this state and furnishes proof satisfactory to the commissioner that it has discharged or otherwise adequately provided for all its obligations to its insureds in this state, the state shall release the deposited securities to the entitled parties on presentation of the state treasurer's receipts for those securities or shall release any filed bond or insurance policy.

(g) At any time the commissioner may enter an order increasing the amount of the deposit, bond or insurance specified under subsections (a), (b) and (c) of this section if he finds there has been a substantial change in the facts including an increase in the amount of premiums, membership fees or similar charges in force in this state on which the original determination was based. Within thirty (30) days after receipt of notice, the organization may submit a request to the commissioner for a hearing on the order for modification. The commissioner shall hold a hearing within thirty (30) days after receipt of the request. Failure to meet the modified requirements within thirty (30) days after a final decision or after expiration of the thirty (30) day period for submitting a

request for hearing is grounds for rehabilitation pursuant to chapter 28 of this code.

26-37-109. Appointment of commissioner as attorney for mechanical breakdown insurance organization; service of process.

Any mechanical breakdown insurance organization desiring to transact business in this state shall file with the commissioner a duly executed instrument whereby the organization shall appoint the commissioner as the attorney of the organization upon whom all lawful process in any action or legal proceeding against it on a contract issued or cause of action arising in this state may be served. In addition, the organization shall agree that any lawful process against it which may be served upon its attorney as provided in this section shall be of the same force and validity as if served upon the organization and that the authority thereof shall continue in force irrevocably so long as any liability of the organization in the state remains outstanding.

26-37-110. Examination of mechanical breakdown insurance organizations; audited financial statement.

(a) Every mechanical breakdown insurance organization is subject to examination by the commissioner in the manner and under the conditions provided for examination of insurers pursuant to W.S. 26-2-116 through 26-2-122. In the examination, the assets of any organization are those assets determined by the commissioner to be available for the payment of the obligations of the organization. In accordance with W.S. 26-2-122, the expense of examination shall be paid by the organization.

(b) Instead of examination under subsection (a) of this section, the commissioner may accept a copy of the most recent financial statement of the organization which has been audited by an independent certified public accountant and which demonstrates that the organization is solvent as determined by generally accepted accounting principles.

26-37-111. Mechanical breakdown insurance organizations; solicitations to purchase.

No person shall solicit or aid in the solicitation of another person to purchase a policy issued by a mechanical breakdown insurance organization not having a certificate of authority procured pursuant to this act.

26-37-112. Mechanical breakdown insurance organizations; misrepresentations as to service contracts.

No mechanical breakdown insurance organization, dealer, representative or other person shall in any manner misrepresent the terms, benefits or privileges of any policy issued by the organization.

26-37-113. Mechanical breakdown insurance organizations; validity of policy.

Any policy made, issued or delivered contrary to this chapter shall be valid and binding on the mechanical breakdown insurance organization.

26-37-114. Mechanical breakdown insurance organizations; required dealer's license.

No person shall act as a mechanical breakdown insurance organization dealer in this state without first procuring a license from the commissioner in accordance with W.S. 26-37-115 through 26-37-119.

26-37-115. Mechanical breakdown insurance organizations; application for dealer's license.

(a) Application for a license as a mechanical breakdown insurance dealer shall be made to the commissioner upon forms prescribed and furnished by the commissioner. As a part of or in connection with any application, the applicant shall furnish information concerning his identity, personal history, experience, business record and other pertinent facts the commissioner may reasonably require.

(b) If the applicant is a firm, partnership or corporation, the application shall in addition to the requirements of subsection (a) of this section:

(i) Contain the names of all members and officers of the firm, partnership or corporation; and

(ii) Designate who is to exercise the powers to be conferred by the license on the firm, partnership or corporation.

(c) The commissioner shall require each individual of a firm, partnership or corporation to furnish information to the extent as if applying for an individual license.

(d) Any person willfully misrepresenting any fact required to be disclosed in any application is subject to the penalties provided by W.S. 26-1-107.

26-37-116. Mechanical breakdown insurance organizations; general conditions for issuance or renewal of dealer's license.

(a) For the protection of the people of this state, the commissioner shall not issue or renew any mechanical breakdown insurance dealer's license:

(i) Unless the applicant is in compliance with this chapter;

(ii) To any person found untrustworthy or incompetent or who has not established to the satisfaction of the commissioner that he is qualified in accordance with this chapter.

26-37-117. Mechanical breakdown insurance organizations; qualifications for dealer's license.

(a) In addition to conditions specified under W.S. 26-37-116, the commissioner shall issue a mechanical breakdown insurance dealer's license only to an individual otherwise complying with this chapter furnishing evidence satisfactory to the commissioner that he:

(i) Is an adult;

(ii) Has been a bona fide resident of this state for at least three (3) months;

(iii) Is a trustworthy person with a good reputation; and

(iv) Has never been convicted of a felony that relates to the mechanical breakdown insurance profession or to the ability to practice as a mechanical breakdown insurance dealer. The commissioner shall have discretion as to whether to issue a license if there has been a relevant conviction.

26-37-118. Mechanical breakdown insurance organizations; form and content of dealer's license.

(a) The commissioner shall prescribe the form of the mechanical breakdown insurance dealer's license which shall contain the:

(i) Name of the licensee and his business address;

(ii) Date of issuance and the date of expiration; and

(iii) Name of the represented mechanical breakdown insurance organization.

26-37-119. Mechanical breakdown insurance organizations; annual renewal of dealer's license; fee.

(a) Mechanical breakdown insurance dealers' licenses are renewable on July 1 of each year.

(b) The license fee is twenty dollars ($20.00) per year.

26-37-120. Mechanical breakdown insurance organizations; grounds for suspension, revocation or refusal to renew dealer's license generally.

(a) The commissioner may suspend, revoke or refuse to renew any mechanical breakdown insurance dealer's license issued under this chapter for any cause specified by this chapter including the following:

(i) A violation or willful participation in a violation of this chapter;

(ii) Obtainment of any license through misrepresentation or fraud;

(iii) Misappropriation, conversion for the use of the licensee or illegal withholding of monies required to be held in a fiduciary capacity;

(iv) Material misrepresentation of the terms or effect of any contract or the engagement in any fraudulent transaction;

(v) A conviction by final judgment of a felony that relates to the mechanical breakdown insurance profession or to

the ability to practice as a mechanical breakdown insurance dealer;

(vi) Incompetency, untrustworthiness or a source of injury or loss to the public as demonstrated in the conduct of affairs under a license;

(vii) Misrepresentation of the qualifications of the licensee's representatives;

(viii) Permitting any individual not registered as a representative with the commissioner to act as a representative;

(ix) Any cause of license suspension or revocation provided under W.S. 26-9-211.

26-37-121. Mechanical breakdown insurance organizations; grounds for suspension, revocation or refusal of dealer's license of firm, partnership or corporation.

A mechanical breakdown insurance dealer's license issued to any firm, partnership or corporation may be suspended, revoked or refused for any cause relating to any individual designated in the license to exercise its powers.

26-37-122. Mechanical breakdown insurance organizations; surrender of revoked or suspended license certificate.

The holder of any mechanical breakdown insurance dealer's license which has been revoked or suspended shall immediately surrender the license certificate to the commissioner.

26-37-123. Mechanical breakdown insurance organizations; representatives of dealers; registration required.

No person shall act as the representative of a dealer for a mechanical breakdown insurance organization unless he has first been registered with the commissioner pursuant to W.S. 26-37-124.

26-37-124. Mechanical breakdown insurance organizations; representatives of dealers; registration requirements; fee; renewal; suspension or revocation.

(a) Any dealer for a mechanical breakdown insurance organization shall register its representatives with the

commissioner by filing an application for registration stating the:

(i) Name and address of the registrant;

(ii) Registrant has been a resident of this state for at least thirty (30) days preceding the date of application;

(iii) Registrant is a trustworthy person with a good reputation; and

(iv) Registrant is familiar with the benefits, costs, coverage and claims procedure of the mechanical breakdown insurance marketed by the dealer.

(b) The dealer shall pay a registration fee of ten dollars ($10.00) for each individual registered under this section.

(c) Upon payment of a renewal fee of ten dollars ($10.00), representative registrations are renewable on the first day of August of each year unless sooner suspended or revoked.

(d) Representative registrations may be suspended or revoked for those causes and subject to the procedure applicable to dealers under this chapter or to agents of insurers under this code.

26-37-125. Types of mechanical breakdown insurance; policy and certificate forms; issuance of policies and certificates.

(a) A mechanical breakdown insurer and a mechanical breakdown insurance organization may write mechanical breakdown insurance as individual, group, blanket or franchise insurance. Each contractual obligation for mechanical breakdown insurance shall be evidenced by a policy. Any insured person under a group policy shall be issued a certificate of coverage.

(b) No policy or certificate of mechanical breakdown insurance shall be issued in this state unless a copy of the form has been filed with and approved by the commissioner.

(c) The commissioner shall not approve any form that does not meet the following requirements:

(i) Policies shall contain a list and description of the mechanical breakdown payments promised or the mechanical breakdowns for which expenses are to be reimbursed, any limits

on the amounts to be paid or reimbursed and procedures to be followed by the insured and the insurer in the event of a claim;

(ii) Policies and certificates shall indicate the name of the insurer and the full address of its principal place of business;

(iii) Certificates issued under group policies shall contain a full statement of the benefits provided, any exceptions and claim procedures but may summarize the other terms of the master policy; and

(iv) No policy except a policy issued by a mutual or reciprocal insurance company may provide for assessments on policyholders or for reduction of benefits for the purpose of maintaining the insurer's solvency.

(d) The department may disapprove a policy or certificate form if it finds that it:

(i) Is unfair, unfairly discriminatory, misleading, ambiguous or encourages misrepresentation or misunderstanding of the contract;

(ii) Provides coverage or benefits or contains other provisions that endanger the insurer's solvency; or

(iii) Is contrary to law.

26-37-126. Filing and approval of contracts; annual reports by organizations.

(a) Contracts made between the organization and its dealers and representatives and contracts with other providers of services under the mechanical breakdown insurance policy shall be filed with and approved by the commissioner.

(b) Organizations shall annually report to the commissioner in reasonably required detail, the number and geographical distribution of providers of services covered by the mechanical breakdown insurance policy with whom it maintains contractual relations and the nature of the relations. For individual insurers or groups of insurers, the commissioner may require more frequent reports.

26-37-127. Rules and regulations.

After notice and hearing, the commissioner may promulgate rules and regulations necessary to carry out this chapter. Rules and regulations promulgated under this chapter are subject to review in accordance with W.S. 28-9-101 through 28-9-108.

26-37-128. Penalty for violation.

Any violation of this chapter is punishable as provided by W.S. 26-1-107.

CHAPTER 38 - LONG-TERM CARE INSURANCE

ARTICLE 1 - IN GENERAL

26-38-101. Short title.

This article shall be known and may be cited as the "Long-Term Care Insurance Act."

26-38-102. Applicability.

The requirements of this article shall apply to policies delivered or issued for delivery in this state on or after the effective date of this article. This article is not intended to supersede the obligations of entities subject to this article to comply with the substance of other applicable insurance laws insofar as they do not conflict with this article, except that laws and regulations designed and intended to apply to medicare supplement insurance policies shall not be applied to long-term care insurance. A policy which is not advertised, marketed or offered as long-term care insurance or nursing home insurance need not meet the requirements of this article.

26-38-103. Definitions.

(a) As used in this article:

(i) "Applicant" means:

(A) In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits;

(B) In the case of a group long-term care insurance policy, the proposed certificate holder.

(ii) "Certificate" means any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in this state;

(iii) "Commissioner" means the insurance commissioner of this state;

(iv) "Group long-term care insurance" means a long-term care insurance policy which is delivered or issued for delivery in this state and issued to:

(A) One (1) or more employers or labor organizations, or to a trust or to the trustees of a fund established by one (1) or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof or for members or former members or a combination thereof, of the labor organizations;

(B) Any professional, trade or occupational association for its members or former or retired members, or combination thereof, if the association:

(I) Is composed of individuals all of whom are or were actively engaged in the same profession, trade or occupation; and

(II) Has been maintained in good faith for purposes other than obtaining insurance; or

(C) An association or a trust or the trustee of a fund established, created or maintained for the benefit of members of one (1) or more associations. Prior to advertising, marketing or offering the policy within this state, the association or associations, or the insurer of the association or associations, shall file evidence with the commissioner that the association or associations has met the organizational requirements of this subparagraph. Thirty (30) days after filing, the association or associations will be deemed to satisfy the organizational requirements unless the commissioner makes a finding that the association or associations do not satisfy those organizational requirements. The evidence filed shall establish that the association or associations has at the outset a minimum of one hundred (100) persons and has been organized and maintained in good faith for purposes other than that of obtaining insurance, has been in active existence for at least one (1) year and has a constitution and bylaws which provide that:

(I) The association or associations hold regular meetings not less than annually to further purposes of the members;

(II) Except for credit unions, the association or associations collect dues or solicit contributions from members; and

(III) The members have voting privileges and representation on the governing board and committees.

(D) A group other than as described in subparagraphs (A), (B) and (C) of this paragraph, subject to a finding by the commissioner that:

(I) The issuance of the group policy is in the best interest of the public;

(II) The issuance of the group policy will result in economies of acquisition or administration; and

(III) The benefits are reasonable in relation to the premiums charged.

(v) "Long-term care insurance" means any insurance policy or rider advertised, marketed, offered or designed to provide coverage for not less than twelve (12) consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis, for one (1) or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care unit of a hospital. The term includes group and individual annuities and life insurance policies or riders which provide directly or which supplement long-term care insurance. The term also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity. The term shall also include qualified long-term care contracts. Long-term care insurance may be issued by insurers, fraternal benefit societies, nonprofit health, hospital and medical service corporations, prepaid health plans, health maintenance organizations or any similar organization to the extent the entity is otherwise authorized to issue life or health insurance. Long-term care insurance shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage,

basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset protection coverage, accident only coverage, specified disease or specified accident coverage or limited benefit health coverage. With regard to life insurance, the term "long-term care insurance" does not include life insurance policies which accelerate the death benefit specifically for one (1) or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement, and which provide the option of a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care. Notwithstanding any other provision contained in this article, other than W.S. 26-38-109(e), any product advertised, marketed or offered as long-term care insurance shall be subject to the provisions of this article;

(vi) "Policy" means any policy, contract, subscriber agreement, certificate, rider or endorsement delivered or issued for delivery in this state by an insurer, fraternal benefit society, nonprofit health, hospital or medical service corporation, prepaid health plan, health maintenance organization or any similar organization;

(vii) "Preexisting condition" means a condition for which medical advice, diagnosis, care or treatment was recommended by, or received from a provider of health care services, within six (6) months preceding the effective date of coverage of an insured person;

(viii) "Qualified long-term care insurance contract" means any life insurance contract which provides long-term care coverage by rider or as part of the contract so long as it is in compliance with the applicable provisions of section 7702B of the Internal Revenue Code, as amended. The term also means any other individual or group insurance contract if it meets the requirements of section 7702(B) of the Internal Revenue Code, as amended, and if:

(A) The only insurance protection provided under the contract is coverage of qualified long-term care services;

(B) The contract does not pay or reimburse expenses incurred for services or items to the extent that such expenses are reimbursable under Title XVIII of the Social Security Act, as amended, or would be so reimbursable but for

the application of a deductible or coinsurance amount. The requirements of this subparagraph do not apply to contracts in which Medicare is a secondary payor, or if the contract makes per diem or other periodic payments without regard to expenses;

(C) The contract is guaranteed renewable;

(D) The contract does not provide for a cash surrender value or other money that can be paid, assigned, pledged as collateral for a loan or borrowed. All refunds of premiums, and all policyholder dividends or similar amounts, under such contract are to be applied as a reduction in future premiums or to increase future benefits, except that a refund of the aggregate premium paid under the contract may be allowed in the event of death of the insured or a complete surrender or cancellation of the contract; and

(E) The contract contains the consumer protection provisions set forth in section 7702B(g) of the Internal Revenue Code.

(ix) "Qualified long-term care services" means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance for personal care services to which an insured is eligible for under a qualified long-term care insurance contract, and which are provided pursuant to a plan of care prescribed by a licensed health care practitioner.

26-38-104. Limits of group long-term care insurance.

No group long-term care insurance coverage may be offered to a resident of this state under a group policy issued in another state to a group described in W.S. 26-38-103(a)(iv)(D), unless this state or another state having statutory and regulatory long-term care insurance requirements substantially similar to those adopted in this state has made a determination that those requirements have been met.

26-38-105. Disclosure and performance standards for long-term care insurance.

(a) The commissioner shall adopt regulations that include standards for full and fair disclosure setting forth the manner, content and required disclosures for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage

provisions, coverage of dependents, preexisting conditions, termination of insurance, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions and definitions of terms.

(b) No long-term care insurance policy shall:

(i) Be cancelled, nonrenewed or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder;

(ii) Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or

(iii) Contain coverage for skilled nursing care only or contain coverage that provides significantly more skilled care in a facility than coverage for lower levels of care.

(c) No long-term care insurance policy or certificate shall use a definition of "preexisting condition" which is more restrictive than the definition provided in this article.

(d) No long-term care insurance policy shall exclude coverage for a loss or confinement which is the result of a preexisting condition unless the loss or confinement begins within six (6) months following the effective date of coverage of an insured person.

(e) The commissioner may extend the limitation periods set forth in subsections (c) and (d) of this section as to specific age group categories in specific policy forms upon finding that the extension is in the best interest of the public.

(f) The definition of "preexisting condition" does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy, a preexisting condition, regardless of whether it is disclosed in the application, need not be covered until the waiting period described in subsection (d) of this section expires. No long-term care insurance policy may exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or

benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in subsection (d) of this section.

(g) No long-term care insurance policy may be delivered or issued for delivery in this state if the policy:

(i) Conditions eligibility for any benefits on a prior hospitalization requirement;

(ii) Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care;

(iii) Conditions eligibility for any benefits, other than waiver of premium, post-confinement, post-acute care or recuperative benefits, on a prior institutionalization requirement; or

(iv) Fails to meet any of the following requirements:

(A) A long-term care insurance policy containing post-confinement, post-acute care or recuperative benefits shall clearly label in a separate paragraph of the policy or certificate entitled "limitations or conditions on eligibility for benefits" the limitations or conditions, including any required number of days of confinement;

(B) A long-term care insurance policy or rider which conditions eligibility of noninstitutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than five (5) days;

(C) No long-term care insurance policy or rider which provides benefits only following institutionalization shall condition the benefits upon admission to a facility for the same or related conditions within a period of less than thirty (30) days after discharge from the institution.

(h) The commissioner shall adopt regulations establishing loss ratio standards for long-term care insurance policies provided that a specific reference to long-term care insurance policies is contained in the regulation.

(j) Long-term care insurance policyholders or certificate holders, shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have

the premium refunded if, after examination of the policy or certificate, the policyholder or certificate holder is not satisfied for any reason. Long-term care insurance policies and certificates shall have a notice prominently printed on the first page of the policy and certificate or attached thereto stating in substance that the policyholder or certificate holder shall have the right to return the policy within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, other than a certificate issued pursuant to a policy issued to a group defined in W.S. 26-38-103(a)(iv)(A), the policyholder or certificate holder is not satisfied for any reason. The premium shall be refunded within ten (10) days, excluding Saturdays, Sundays and legal holidays, from the date the policy or certificate is returned. If the premium required to be refunded under this subsection is not refunded within the time periods specified it shall draw interest at the maximum rate allowed for a credit service charge under W.S. 40-14-212(b). No company issuing a long-term care insurance policy shall be required to pay any claim under the terms of the policy until the expiration of the thirty (30) day period. If an application for a qualified long-term care contract is denied, the issuer shall refund to the applicant any premium refund within thirty (30) days of the denial.

(k) An outline of coverage shall be delivered to a prospective applicant at the time of the initial solicitation through means which prominently direct the attention of the recipient to the document and its purpose. The commissioner shall prescribe a standard format of the outline of coverage, including style, arrangement, overall appearance and content. In the case of agent solicitations, an agent shall deliver the outline of coverage prior to the presentation of an application or enrollment form. In the case of direct response solicitations, the outline of coverage shall be presented in conjunction with any application or enrollment form. In the case of a group policy, the outline shall be delivered to certificate holders when the certificate is delivered. The outline of coverage shall include:

(i) A description of the principal benefits and coverage provided in the policy;

(ii) A statement of the principal exclusions, reductions and limitations contained in the policy;

(iii) A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium. Continuation or conversion provisions of group coverage shall be specifically described;

(iv) A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;

(v) A description of the terms under which the policy or certificate may be returned and premium refunded;

(vi) A brief description of the relationship of cost of care and benefits; and

(vii) If the policy or certificate is intended to be a qualified long-term care insurance contract, a statement that discloses to the policyholder or certificate holder that the policy is intended to be a qualified long-term care insurance contract.

(m) Repealed by Laws 1993, ch. 212, § 3.

(n) Repealed by Laws 1993, ch. 212, § 3.

(o) The issuer of a long-term care insurance contract shall deliver to the applicant, policyholder or certificate holder, the contract or certificate of insurance no later than thirty (30) days after the date of approval. At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy which provides long-term care benefits within the policy or rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request, but regardless of request shall make the delivery no later than at the time of policy delivery. In addition to complying with all applicable requirements, the summary shall also include:

(i) An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;

(ii) An illustration of the amount of benefits, the length of benefits, and guaranteed lifetime benefits if any, for each covered person;

(iii) Any exclusions, reductions and limitations on benefits of long-term care; and

(iv) If applicable to the policy type, the summary shall also include:

(A) A disclosure of the effects of exercising other rights under the policy;

(B) A disclosure of guarantees related to long-term care costs of insurance charges; and

(C) Current and projected maximum lifetime benefits.

(p) If any long-term care benefit, funded through a life insurance vehicle by the acceleration of the death benefit, is in benefit payment status, a monthly report shall be provided to the policyholder. The report shall include:

(i) Any long-term care benefits paid out during the month;

(ii) An explanation of any changes in the policy, including, but not limited to, death benefits or cash values, due to long-term care benefits; and

(iii) The amount of long-term care benefits existing or remaining.

(q) If a claim under a long-term care insurance contract is denied, the issuer shall, within sixty (60) days of the date of a written request by the policyholder, or certificate holder or an authorized representative:

(i) Provide a written explanation of the reason for the denial; and

(ii) Make available all information directly related to the denial.

(r) Long-term care insurance premium rate increases shall be based on accepted actuarial principles and practices. All long-term care insurance premium rate increases shall be subject to the approval of the commissioner.

26-38-106. Rulemaking authority.

The commissioner shall adopt reasonable rules and regulations necessary to carry out the provisions of this article in accordance with W.S. 26-2-110.

26-38-107. Incontestability period.

(a) For a long-term care insurance policy or certificate that has been in force for less than six (6) months, an insurer may rescind the policy or certificate or deny any otherwise valid long-term care insurance claim upon a showing of misrepresentation that is material to the acceptance of coverage.

(b) For a long-term care insurance policy or certificate that has been in force for at least six (6) months but less than two (2) years, an insurer may rescind the policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is both material to the acceptance for coverage and which pertains to the conditions for which benefits are sought.

(c) After a long-term care insurance policy or certificate has been in force for two (2) years it is not contestable upon the grounds of misrepresentation, unless the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.

(d) No long-term care insurance policy or certificate may be field issued based on medical or health status. For purposes of this section, "field issued" means a policy or certificate issued by an agent or a third party administrator pursuant to the underwriting authority granted to the agent or third party administrator by an insurer.

(e) If an insurer has paid benefits under the long-term care insurance policy or certificate, the benefit payments may not be recovered by the insurer in the event that the policy or certificate is rescinded.

(f) An insurer shall rescind a long-term care policy or certificate for misrepresentation only as provided in this section.

26-38-108. Third party notice and reinstatement.

(a) Each insurer offering long-term care insurance shall, as a protection against unintentional lapse, comply with the following:

(i) No individual long-term care policy or certificate shall be issued until the insurer has received from the applicant either a written designation of at least one (1) person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice. The applicant has the right to designate at least one (1) person who is to receive the notice of termination, in addition to the insured. A designation shall not constitute acceptance of any liability by the third party for services provided to the insured. The form used for the written designation shall provide space clearly designated for listing at least one (1) person. The designation shall include each person's full name and home address. In the case of an applicant who elects not to designate an additional person, the waiver shall state: "Protection against unintended lapse." "I understand that I have the right to designate at least one (1) person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. I elect not to designate any person to receive such notice." The insurer shall notify the insured of the right to change the written designation, no less than once every two (2) years;

(ii) When the policyholder or certificate holder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in paragraph (a)(i) of this section need not be met until sixty (60) days after the policyholder or certificate holder is no longer enrolled in the payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant;

(iii) No long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the insurer, at least thirty (30) days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to paragraph (a)(i) of this section, at the address provided by the insured, to receive notice of lapse or termination. Notice shall be given by first

class United States mail, postage prepaid. Notice shall not be given until thirty (30) days after a premium is due and unpaid. Notice shall be deemed to have been given as of five (5) days after the date of mailing.

(b) In addition to the requirements in subsection (a) of this section, a long-term care insurance policy or certificate shall include a provision which provides for reinstatement of coverage, in the event of lapse if the insurer is provided proof of cognitive impairment or the loss of functional capacity. This option shall be available to the insured if requested within five (5) months after termination and shall allow for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria on cognitive impairment or the loss of functional capacity, if any, contained in the policy or certificate.

26-38-109. Nonforfeiture benefit provisions.

(a) Subject to subsection (g) of this section, an insurer that offers a long-term care insurance policy or certificate in this state shall offer a nonforfeiture protection provision as an option. The nonforfeiture benefit shall be made available in the event of a default in the payment of any premiums, or upon the surrender of the policy or certificate by the policyholder or certificate holder.

(b) Subject to subsection (g) of this section, the nonforfeiture provision offered for a policy which is not intended to be a qualified long-term insurance contract, shall be appropriately captioned and shall provide at least one (1) of the following:

(i) Reduced paid-up insurance;

(ii) Extended term insurance;

(iii) Cash surrender values;

(iv) A return of premium;

(v) A shortened benefit period; or

(vi) Other offerings as approved by the commissioner.

(c) Nonforfeiture benefits shall be computed in an actuarially sound manner, using a methodology that has been filed with and approved by the commissioner. At the time of lapse, or upon request by the policyholder or certificate holder, the insurer shall disclose the then-accrued nonforfeiture values. At the time the policy or certificate is issued, the insurer shall provide to the policyholder or certificate holder schedules demonstrating estimated values of nonforfeiture benefits. The schedules shall state that the estimated values are not to be construed as guaranteed nonforfeiture values.

(d) The amount of nonforfeiture benefits shall be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency and interest as reflected in changes in rates for premium paying policies approved by the commissioner for the same policy form.

(e) This section does not apply to life insurance policies or riders containing accelerated long-term care benefits.

(f) Nonforfeiture benefits for qualified long-term care insurance contracts shall include at least a reduced paid-up insurance benefit, an extended term insurance benefit, the offer of a shortened benefit period, or other similar offerings approved by the secretary of the treasury, and shall be provided as specified in regulations. The issuer of such a contract may refund premiums upon complete surrender or cancellation of the contract or policy, as long as the refund does not exceed the aggregate premiums paid for the contract or policy.

(g) Within fifteen (15) business days following receipt of written proof of the death of an insured, an insurer under this chapter shall refund unearned premiums paid for any period beyond the death of the insured. The amount of the refund shall be pro rata from the date of death.

26-38-110. Compliance with article required.

No policy shall be advertised, marketed or offered as long-term care or nursing home insurance unless it complies with the provisions of this article.

26-38-111. Penalties.

In addition to any other penalties provided by the laws of this state, any insurer or agent who violates any requirement of this

state relating to the regulation of long-term care insurance or the marketing of such insurance shall be subject to a civil penalty not to exceed three (3) times the amount of any commissions paid for each policy involved in the violation or ten thousand dollars ($10,000.00), whichever is greater. The penalty shall be assessed by the commissioner in accordance with W.S. 26-1-107.

ARTICLE 2 - MEDICARE SUPPLEMENT INSURANCE

26-38-201. Definitions.

(a) As used in this act:

(i) "Applicant" means:

(A) In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits; and

(B) In the case of a group Medicare supplement policy, the proposed certificate holder.

(ii) "Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare supplement policy;

(iii) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer;

(iv) "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates;

(v) "Medicare supplement policy" means a group or individual disability insurance policy or a subscriber contract of hospital and medical service associations or health maintenance organizations other than a policy issued pursuant to a contract under section 1876 of the federal Social Security Act, or an issued policy under a demonstration project specified in 42 U.S.C. 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare;

(vi) "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended;

(vii) "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer;

(viii) "This act" means W.S. 26-38-201 through 26-38-209.

26-38-202. Applicability and scope.

(a) Except as otherwise specifically provided, this act shall apply to:

(i) All Medicare supplement policies delivered or issued for delivery in this state on or after the effective date of this act; and

(ii) All certificates issued under group Medicare supplement policies which have been delivered or issued for delivery in this state.

(b) This act shall not apply to a policy issued to one (1) or more employers or labor organizations, or to the trustees of a fund established by one (1) or more employers or labor organizations, or combination thereof, for employees or former employees or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

(c) Except as provided by regulations adopted pursuant to W.S. 26-38-206(e), the provisions of this act are not intended to prohibit or apply to insurance policies or health care benefit plans, including group conversion policies, provided to Medicare eligible persons which policies are not marketed or held to be Medicare supplement policies or benefit plans.

26-38-203. Standards for policy provisions.

(a) No Medicare supplement insurance policy or certificate in force in the state shall contain benefits which duplicate benefits provided by Medicare.

(b) The commissioner shall adopt reasonable regulations to establish specific standards for policy provisions of Medicare supplement policies and certificates. The standards shall be in addition to and in accordance with applicable laws of this

state. No requirement of the code relating to minimum required policy benefits, other than the minimum standards contained in this act, shall apply to Medicare supplement policies and certificates. The standards may cover, but are not limited to:

(i) Terms of renewability;

(ii) Initial and subsequent conditions of eligibility;

(iii) Nonduplication of coverage;

(iv) Probationary periods;

(v) Benefit limitations, exceptions and reductions;

(vi) Elimination periods;

(vii) Requirements for replacement;

(viii) Recurrent conditions; and

(ix) Definitions of terms.

(c) The commissioner shall adopt reasonable regulations that specify prohibited policy provisions not otherwise specifically authorized by statute which, in the opinion of the commissioner, are unjust, unfair or unfairly discriminatory to any person insured or proposed for coverage under a Medicare supplement policy or certificate.

(d) Notwithstanding any other provision of law or contract, a Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than ninety (90) days from the effective date of coverage because the loss involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within ninety (90) days before the effective date of coverage.

26-38-204. Regulations.

(a) The commissioner shall adopt reasonable regulations to establish minimum standards for benefits, claims payment, marketing practices, compensation arrangements and reporting practices for Medicare supplement policies and certificates.

(b) The commissioner may adopt reasonable regulations necessary to conform Medicare supplement policies and certificates to the requirements of federal law and regulations, including but not limited to:

(i) Requiring refunds or credits if the policies or certificates do not meet loss ratio requirements;

(ii) Establishing a uniform methodology for calculating and reporting loss ratios;

(iii) Assuring public access to policies, premiums and loss ratio information of issuers of Medicare supplement insurance;

(iv) Establishing a process for approving or disapproving policy forms and certificate forms and restricting premium increases if loss ratio requirements are not met;

(v) Establishing a policy for holding public hearings prior to approval of premium increases; and

(vi) Establishing standards for Medicare select policies and certificates.

26-38-205. Loss ratio standards.

(a) Repealed by Laws 1992, ch. 57, § 2.

(b) Medicare supplement policies shall return to policyholders benefits which are reasonable in relation to the premium charged. The commissioner shall issue reasonable regulations to establish minimum standards for loss ratios of Medicare supplement policies on the basis of incurred claims experience, or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis, and earned premiums in accordance with accepted actuarial principles and practices.

26-38-206. Disclosure standards.

(a) In order to provide for full and fair disclosure in the sale of Medicare supplement policies, no Medicare supplement policy or certificate shall be delivered in this state unless an outline of coverage is delivered to the applicant at the time application is made.

(b) The commissioner shall prescribe both the format and content of the outline of coverage required by subsection (a) of this section. For purposes of this section, "format" means style, arrangements and overall appearance, including such items as the size, color and prominence of type and arrangement of text and captions. The outline of coverage shall include but is not limited to:

(i) A description of the principal benefits and coverage provided in the policy;

(ii) A statement of the exceptions, reductions and limitations contained in the policy;

(iii) A statement of the renewal provisions, including any reservation by the insurer of a right to change premiums and disclosure of the existence of any automatic renewal premium increases based on the policyholder's age;

(iv) A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions.

(c) The commissioner may prescribe by regulation a standard form and the contents of an informational brochure for persons eligible for Medicare, which is intended to improve the buyer's ability to select the most appropriate coverage and improve the buyer's understanding of Medicare. Except in the case of direct response insurance policies, the commissioner may require by regulation that the information brochure be provided to any prospective insureds eligible for Medicare concurrently with delivery of the outline of coverage. With respect to direct response insurance policies, the commissioner may require by regulation that the prescribed brochure be provided upon request to any prospective insureds eligible for Medicare, but in no event later than the time the policy is delivered.

(d) The commissioner may adopt reasonable regulations for captions or notice requirements determined to be in the public interest and designed to inform prospective insureds that particular insurance coverages are not Medicare supplement coverages, for all disability insurance policies sold to persons eligible for Medicare, other than:

(i) Medicare supplement policies; or

(ii) Disability income policies.

(iii) Repealed By Laws 1997, ch. 12, § 2.

(iv) Repealed By Laws 1997, ch. 12, § 2.

(e) The commissioner may further adopt reasonable regulations to govern the full and fair disclosure of the information in connection with the replacement of disability policies, subscriber contracts or certificates by persons eligible for Medicare.

26-38-207. Notice of free examination.

Medicare supplement policies or certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the full premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Any refund made pursuant to this section shall be paid directly to the applicant by the insurer in a timely manner.

26-38-208. Filing requirements for advertising.

Every issuer of Medicare supplement insurance policies or certificates in this state shall provide to the insurance commissioner a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio or television medium, for review by the commissioner.

26-38-209. Penalties.

(a) In addition to any other applicable penalties for violations of this code, the commissioner may:

(i) Require insurers to cease marketing any Medicare supplement policy or certificate in this state which violates any provision of this act, any other law administered by the commissioner, any regulation promulgated pursuant to this act or any other rule promulgated pursuant to the authority of the commissioner; or

(ii) Require the insurer to take any actions necessary to comply with the provisions of this act.

CHAPTER 39 - CLOSED BLOCKS OF BUSINESS

26-39-101. Scope.

(a) This chapter shall apply to any insurer who has marketed or sold or will market and sell any individual, group or blanket disability insurance contracts to Wyoming residents.

(b) For the purposes of this chapter disability insurance does not include credit disability insurance as defined in W.S. 26-21-102(a)(ii).

26-39-102. Definitions.

(a) As used in this act:

(i) "Block of business" means all those individual, group or blanket disability insurance contracts issued by an insurance company under a particular policy form approved by the Wyoming insurance department;

(ii) "Closed block of business" means a block of business where an insurer ceases to market or sell in Wyoming any new individual, group or blanket disability insurance contracts under a particular policy form and no new contracts are being added to the block;

(iii) "Policy form" means a representative insurance contract which has been filed by an insurer for approval by the Wyoming insurance department pursuant to W.S. 26-15-110 so that other contracts with identical language to that of the policy form may be marketed and sold in Wyoming;

(iv) "This act" means W.S. 26-39-101 through 26-39-104.

26-39-103. Spreading of risk.

If any insurer closes a block of business in this state, the insurer shall spread the claims experience of the closed block of business to, for like insureds without regard to individual health problems, other blocks of business still being marketed and sold by that insurer in this state when determining what premiums are to be charged for the contracts included in the closed block of business.

26-39-104. Violations.

Any insurer who violates any provisions of this chapter is subject to denial, suspension or revocation of its certificate of authority as well as the imposition of a penalty as set forth in W.S. 26-1-107.

CHAPTER 40 - HEALTHCARE CLAIMS UNDER SPECIFIED STANDARDS

ARTICLE 1 - PAYMENT OF CLAIMS UNDER USUAL, CUSTOMARY AND REASONABLE BASIS

26-40-101. Scope.

This chapter applies to all insurers who solicit or offer for sale in this state individual, group disability or blanket disability policies covering Wyoming residents.

26-40-102. Definitions.

(a) As used in this chapter:

(i) "Health care provider" means any physician, hospital or other person licensed or otherwise authorized in this or another state to furnish to any individual medical or dental care, vision care or hospitalization incident to the furnishing of that care or hospitalization for the purpose of preventing, alleviating, curing or healing human illness, injury or physical disability;

(ii) "Usual, customary and reasonable basis" means the method by which an insurer determines the amount to be paid on a claim for disability benefits by comparing the amount of the claim to amounts charged by other health care providers for the same or similar medical services or procedures;

(iii) "Medical necessity," means:

(A) A medical service, procedure or supply provided for the purpose of preventing, diagnosing or treating an illness, injury, disease or symptom and is a service, procedure or supply that:

(I) Is medically appropriate for the symptoms, diagnosis or treatment of the condition, illness, disease or injury;

(II) Provides for the diagnosis, direct care and treatment of the patient's condition, illness, disease or injury;

(III) Is in accordance with professional, evidence based medicine and recognized standards of good medical practice and care; and

(IV) Is not primarily for the convenience of the patient, physician or other health care provider.

(B) A medical service, procedure or supply shall not be excluded from being a medical necessity under this section solely because the service, procedure or supply is not in common use if the safety and effectiveness of the service, procedure or supply is supported by:

(I) Peer reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medicus (EMBASE); or

(II) Medical journals recognized by the Secretary of Health and Human Services under Section 1861(t)(2) of the federal Social Security Act.

26-40-103. Payment of claims.

(a) If any disability insurance policy provides for settlement of a claim for payment of medical services or procedures provided by a health care provider using a usual, customary and reasonable basis the insurer shall:

(i) Submit to the department upon request statistical data of health care provider's charges on which the insurer bases payment of claims. Such data shall be submitted upon request of the commissioner, provided, however, no insurer may be required to submit data more than once every six (6) months. The data submitted shall contain only charges for services performed not more than one (1) year prior to the date of the most recent data;

(ii) Provide to the claimant, in writing, a complete explanation of the basis of settlement, if requested by the

claimant in writing, and maintain the explanation in the claim file. If the basis of payment is less than the actual charge made by the health care provider, the explanation shall state the specific reason for the amount not paid and may not expressly state that the health care provider is overcharging unless the allegation is substantiated by fact set out in the explanation;

(iii) Settle any claim for medical services or procedures only on the basis of charges made by Wyoming health care providers of similar qualifications or experience for the same or similar medical services or procedures if the service or procedure for which payment is sought was obtained in Wyoming. However, if the profile or survey does not contain a statistically credible sample of charges, the insurer may include in the profile or survey charges from another similar geographic and demographic area so that a reliable basis is established.

(b) Statistical data submitted to the department pursuant to this section shall be confidential in nature and not available for public inspection.

(c) When a disability insurance policy provides for settlement of a claim for payment of medical services or procedures provided by a health care provider using a usual, customary and reasonable basis or any similar basis:

(i) If the commissioner, based either on a review of the statistical data submitted pursuant to subsection (a) of this section or on the receipt of complaints from one (1) or more insureds, has reason to suspect that a claim or one (1) or more classes of claims is not being settled on the basis provided by the policy he may order the company to show cause why the settlement or settlements should not be changed;

(ii) If the commissioner finds, after notice and opportunity for hearing, that the company is not settling a claim or one (1) or more classes of claims on the basis provided by the policy, he may order a different settlement or settlements.

26-40-104. Prohibitions.

(a) No person may make payment on a claim for benefits under an individual, group or blanket disability policy covering

residents of this state unless such claim payment is made in compliance with this chapter.

(b) Any person who violates any provisions of this chapter is subject to denial, suspension or revocation of a license or certificate of authority in addition to the imposition of any other penalty provided by W.S. 26-1-107.

ARTICLE 2 - MEDICAL NECESSITY STANDARD

26-40-201. Payment of claims under medical necessity standard; review.

(a) As used in this section, "medical necessity or other similar basis" includes, but is not limited to, "medically necessary," "medically necessary care" and "medically necessary and appropriate," as defined in W.S. 26-40-102(a)(iii).

(b) If any insurance policy provides for settlement of a claim for payment of medical services, procedures or supplies provided by a health care provider using a medical necessity or other similar basis the insurer shall:

(i) Define medical necessity or other similar basis as "medical necessity" is defined in this chapter and W.S. 26-40-102(a)(iii);

(ii) Make all determinations whether a medical service, procedure or supply is medically necessary based only upon the factors stated in the definition of medical necessity contained in W.S. 26-40-102(a)(iii);

(iii) Provide internal review and external review procedures for all denied claims as required in this section and disclose all procedures, time lines and requirements for such review procedures in every insurance policy and as otherwise required in this section.

(c) When any claim for the provision of or payment for medical services, procedures or supplies is first denied as not being a medical necessity, or on another similar basis, the insurer shall provide to the claimant, in writing, a complete explanation of the basis for the settlement and shall specify why the services, procedures or supplies requested are not medically necessary. Such explanation shall also include:

(i) A statement in the following, or substantially equivalent, language: "We have denied your request for the provision of or payment for a health care service or course of treatment. You have the right to have our decision reviewed by following the procedures outlined in this notice. You also may have the right to an expedited review under circumstances where a delayed review would adversely affect you."; and

(ii) A statement describing a procedure for having the claim denial reviewed by the insurer, including all applicable time limits, requirements and a process for having a expedited review initiated as expeditiously as the claimant's medical condition or circumstances require, and in any event within seventy-two (72) hours, where:

(A) The timeframe for the completion of a normal review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function; or

(B) The claimant's claim concerns a request for an admission, availability of care, continued stay or health care service for which the claimant received emergency services, but has not been discharged from a health care facility.

(d) A claimant shall have not less than thirty (30) days in which to file a request for the review provided in subsection (c) of this section and such review shall be completed by the insurer, and a decision delivered to the claimant, no later than forty-five (45) days after receipt of a request for review.

(e) If a claim for the provision of or payment for medical services, procedures or supplies is denied on the basis that it is not a medical necessity, or on other similar basis, after having been reviewed by the insurer pursuant to subsection (c) or (d) of this section, the insurer shall provide to the claimant, in writing, a complete explanation of the basis for the decision and shall specify why the services, procedures or supplies requested are not medically necessary. Such explanation shall also include:

(i) The signed opinion of at least one (1) credited medical consultant who agrees with the denial and who is not an employee of the insurer if requested by the claimant;

(ii) A statement in the following, or substantially equivalent, language: "We have denied your request for the

provision of or payment for a health care service or course of treatment. You may have the right to have our decision reviewed by health care professionals who have no association with us and is not the attending physician or the physician's partner by following the procedures outlined in this notice. You also may have the right to an expedited review under circumstances where a delayed review would adversely affect you."; and

(iii) A statement describing the procedure for having the denied claim reviewed by an external review organization pursuant to regulations adopted by the commissioner. The statement shall include a description of all procedures, time limits and requirements, including those related to expedited reviews, which the claimant must follow to obtain an external review and include a request for external review form and release of records form approved by the commissioner.

(f) Within one hundred twenty (120) days of receiving the written explanation required by subsection (e) of this section, a claimant may request an external review of the decision which is the subject of the explanation by filing a written request for such review. The request shall be submitted to the insurer on a form approved by the commissioner, unless such form was not provided to the claimant as required by subsection (e) of this section, in which event any written request for an external review shall be sufficient.

(g) Upon receiving a request for external review, the insurer shall:

(i) Immediately send a copy of the request to the commissioner;

(ii) Assign the request to an independent review organization that has been approved by the commissioner for a preliminary review. The insurer shall provide to the independent review organization all documents and information upon which the insurer relied in denying all claims under review. Failure to provide the documents and other information shall not delay the conduct of the external review. The independent review organization shall determine whether:

(A) The claimant is or was a covered person in the insurance policy at the time the provision of or payment for medical services, procedures or supplies was requested or provided;

(B) The provision of or payment for medical services, procedures or supplies requested by the claimant reasonably appears to be a covered service under the insurance policy, but for the determination by the insurer that the services, procedures or supplies are not a medical necessity;

(C) The insurer has denied the claimant's request for the provision of or payment for medical services, procedures or supplies after having been given the opportunity to review the insurer's first denial one (1) or more times;

(D) The claimant has provided to the insurer all the information and forms required to process an external review, including a release form, approved by the commissioner, by which the claimant authorizes the release of protected health information pertinent to the external review.

(h) The independent review organization shall within five (5) days determine whether the documentation is complete and immediately notify the claimant and the insurer in writing whether the documentation is complete and, if not, what information or documentation is missing. The claimant may submit in writing to the independent review organization any additional supporting documentation that the independent review organization should consider or may require when conducting its external review. If the request for review is not complete, the independent review organization shall require from the insurer or the claimant the information or materials needed to make the request complete.

(j) The independent review organization shall, within one (1) business day of its receipt, forward all documentation and information it receives from an insurer or claimant to the opposing insurer or claimant. The insurer may use any documentation or other information provided by the claimant to reconsider its settlement of the claims. If the insurer chooses to reverse its prior decision, it shall immediately provide written notice to the claimant, the independent review organization and the commissioner, at which time the review shall be terminated.

(k) In addition to the documents and information provided pursuant to this section, the independent review organization, to the extent the information is available and the independent review organization considers them appropriate, shall consider the following in reaching its decision:

(i) The claimant's medical records;

(ii) The attending health care professional's recommendation;

(iii) Consulting reports from appropriate health care professionals and other documents submitted by the insurer, claimant or the claimant's treating provider;

(iv) The terms of coverage under the claimant's insurance policy;

(v) The standards identified in W.S. 26-40-102(a)(iii);

(vi) All evidence based research used in the insurer's denial of the claim.

(m) Within forty-five (45) days after the date of receipt of the request for external review, the assigned independent review organization shall provide written notice to the claimant, the insurer and the commissioner of its decision to uphold or reverse the decision of the insurer that the provision of or payment for medical services, procedures or supplies requested by the claimant are not medically necessary. Such written notice shall include:

(i) A general description of the reason for the request for external review;

(ii) The date the independent review organization received the assignment from the insurer to conduct the review;

(iii) The date the external review was conducted;

(iv) The date of its decision;

(v) The principal reasons for its decision;

(vi) The rationale for its decision; and

(vii) References to the evidence or documentation considered in reaching its decision.

(n) In the event the external review organization determines the claims should be allowed, the insurer shall approve the request for the provision of or payment for medical

services, procedures or supplies that was the subject of the review and notify the claimant of such approval within five (5) days.

(o) The engagement by an insurer of an independent review organization to conduct an external review in accordance with this section shall be fair and impartial. The insurer, insured and the independent review organization shall comply with regulations promulgated by the commissioner to ensure fairness and impartiality in the engagement of approved independent review organizations, in the terms, termination and payment of independent review organizations and in the review process.

(p) The commissioner shall adopt regulations establishing an expedited review by an external review organization as expeditiously as the claimant's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the date of receipt of the request for an expedited external review, and which allows an expedited external review where:

(i) The timeframe for the completion of a normal external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function; or

(ii) The claimant's claim concerns a request for an admission, availability of care, continued stay or health care service for which the claimant received emergency services, but has not been discharged from a health care facility.

(q) The insurer against whom a request for external review is filed shall pay the costs of the independent review organization's external review.

(r) The commissioner shall adopt such regulations as are necessary to promote the purposes of this section, which regulations shall include:

(i) Fees, including the waiver of fees for indigent persons;

(ii) Standards and procedures for the approval of independent review organizations;

(iii) External review organization reporting and record retention requirements.

(s) An insurer required to comply with the notification and appeal procedures of the Employee Retirement Income Security Act, and being compliant therewith, shall be deemed in compliance with this section.

CHAPTER 41 - REDOMESTICATION MODEL ACT

26-41-101. Approval as a domestic insurer.

Any insurer which is organized under the laws of any jurisdiction other than this state and is admitted to do business in this state for the purpose of writing insurance may become a domestic insurer by meeting the substantive requirements of law relative to the organization and licensing of a domestic insurer of the same type, by designating its principal place of business at a place in this state, and by receiving from the commissioner certification that it is a domestic insurer as if originally formed in the state. The domesticated insurer thereafter will be entitled to domestic certificates and licenses to transact business in this state, and shall be subject to the authority and jurisdiction of this state as a domestic insurer.

26-41-102. Conversion to foreign insurer.

Any domestic insurer may, upon the approval of the commissioner, transfer its domicile to any other state in which it is admitted to transact the business of insurance, and upon such a transfer shall cease to be a domestic insurer, and shall be admitted to this state if qualified as a foreign insurer. The commissioner shall approve any proposed transfer unless he shall determine the transfer is not in the interest of the policyholders of this state.

26-41-103. Effects of redomestication.

(a) The certificate of authority, agent appointments and licenses, rates, and other items which the commissioner of insurance allows, in his discretion, which are in existence at the time any insurer licensed to transact the business of insurance in this state transfers its corporate domicile to this or any other state by merger, consolidation, continuance, transfer or any other lawful method shall continue in full force and effect upon the transfer if the insurer remains duly qualified to transact the business of insurance in this state. All outstanding policies of any transferring insurer shall

remain in full force and effect and need not be endorsed as to the new name of the company or its new location unless so ordered by the commissioner. Every transferring insurer shall file new policy forms with the commissioner on or before the effective date of the transfer, but may use existing policy forms with appropriate endorsements if allowed by, and under conditions approved by, the commissioner.

(b) The procedures for filing and approval of articles of domestication by the corporate directors shall be the same as those set forth in W.S. 26-24-104 concerning the filing and approval of articles of incorporation for proposed domestic insurers.

(c) The articles of domestication of any insurer transferring its domicile into this state shall be deemed the articles of incorporation of the insurer. The domestication of an insurer into this state shall have the same effect upon the insurer as in the case of a corporation continuing in Wyoming pursuant to W.S. 17-16-1810.

CHAPTER 42 - WYOMING LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

26-42-101. Short title.

This chapter is known as the "Wyoming Life and Health Insurance Guaranty Association Act."

26-42-102. Definitions.

(a) As used in this act:

(i) "Account" means any of the three (3) accounts created by W.S. 26-42-104(a);

(ii) "Association" means the Wyoming life and health insurance guaranty association created by W.S. 26-42-104;

(iii) "Authorized assessment" or the term "authorized" when used in the context of assessments means a resolution by the board of directors has been passed whereby an assessment will be called immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution is passed;

(iv) "Benefit plan" means a specific employee, union or association of natural persons benefit plan;

(v) "Called assessment" or the term "called" when used in the context of assessments means that a notice has been issued by the association to member insurers requiring that an authorized assessment be paid within the time frame set forth within the notice. An authorized assessment becomes a called assessment when notice is mailed by the association to member insurers;

(vi) "Contractual obligation" means any obligation under a policy or contract or certificate under a group policy or contract, or portion thereof for which coverage is provided under W.S. 26-42-103;

(vii) "Covered policy" or "covered contract" means any policy or contract or portion of a policy or contract for which coverage is provided by W.S. 26-42-103;

(viii) "Extra-contractual claims" shall include claims relating to bad faith in the payment of claims, punitive or exemplary damages or attorneys' fees and costs;

(ix) "Impaired insurer" means a member insurer which is not an insolvent insurer and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction;

(x) "Insolvent insurer" means a member insurer which after the effective date of this act, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency;

(xi) "Member insurer" means any insurer or health maintenance organization which is licensed or holds a certificate of authority to transact in this state any kind of insurance or health maintenance organization business for which coverage is provided by W.S. 26-42-103 and includes any insurer or health maintenance organization business whose license or certificate of authority in this state may have been suspended, revoked, not renewed or voluntarily withdrawn, but does not include:

(A) Repealed By Laws 1997, ch. 125, § 1.

(B) Repealed by Laws 1995, ch. 210, § 5.

(C) A fraternal benefit society;

(D) A mandatory state pooling plan;

(E) A stipulated premium insurance company;

(F) A local mutual burial association;

(G) A mutual assessment company or any entity that operates on an assessment basis;

(H) An insurance exchange; or

(J) Any entity similar to any of the above.

(xii) "Moody's Corporate Bond Yield Average" means the Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto;

(xiii) "Owner" of a policy or contract, "contract owner", "policyholder" and "policy owner" mean the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the member insurer. The terms "owner", "contract owner", "policyholder" and "policy owner" do not include persons with a mere beneficial interest in a policy or contract;

(xiv) "Plan sponsor" means:

(A) The employer in the case of a benefit plan established or maintained by a single employer;

(B) The employee organization in the case of a benefit plan established or maintained by an employee organization; or

(C) In a case of a benefit plan established or maintained by two (2) or more employers or jointly by one (1) or more employers and one (1) or more employee organizations, the association, committee, joint board of trustees or other similar group of representatives of the parties who establish or maintain the benefit plan.

(xv) "Premiums" means amounts received on covered policies or contracts less premiums, considerations and deposits returned thereon, and less dividends and experience credits thereon, but does not include any amounts received for any policies or contracts or for the portions of any policies or contracts for which coverage is not provided by W.S. 26-42-103(b) except that assessable premium shall not be reduced due to W.S. 26-42-103(c)(iii) relating to interest limitations and W.S. 26-42-103(d)(ii) relating to limitations with respect to any one (1) individual, one (1) participant and one (1) policy owner or contract owner. "Premiums" shall not include:

(A) Premiums on an unallocated annuity contract; or

(B) With respect to multiple nongroup policies of life insurance owned by one (1) owner, whether the policy owner or contract owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, premiums in excess of five million dollars ($5,000,000.00) with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.

(xvi) "Principal place of business" of:

(A) A plan sponsor or a person other than a natural person means the single state in which the natural persons who establish policy for the direction, control and coordination of the operations of the entity as a whole primarily exercise that function, determined by the association in its reasonable judgment by considering the following factors:

(I) The state in which the primary executive and administrative headquarters of the entity is located;

(II) The state in which the principal office of the chief executive officer of the entity is located;

(III) The state in which the board of directors, or similar governing person or persons, of the entity conducts the majority of its meetings;

(IV) The state in which the executive or management committee of the board of directors, or similar

governing person or persons, of the entity conducts the majority of its meetings;

(V) The state from which the management of the overall operations of the entity is directed; and

(VI) In the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the above factors. However, in the case of a plan sponsor, if more than fifty percent (50%) of the participants in the benefit plan are employed in a single state, that state shall be deemed the principal place of business for the plan sponsor.

(B) A plan sponsor of a benefit plan shall be deemed to be the principal place of business of the association, committee, joint board of trustees or other similar group of representatives of the parties who establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, shall be deemed to be the principal place of business or the employer or employee organization that has the largest investment in the benefit plan in question.

(xvii) "Receivership court" means the court in the insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation or liquidation of the member insurer;

(xviii) "Resident" means a person to whom a contractual obligation is owed and who resides in this state on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer. A person may be a resident of only one (1) state, which in the case of a person other than a natural person is its principal place of business. Citizens of the United States who are either residents of foreign countries or residents of United States possessions, territories or protectorates that do not have an association similar to the association created by this act, shall be deemed residents of the state of domicile of the member insurer that issued the policies or contracts;

(xix) "Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a

plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant;

(xx) "Supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, health or annuity policy or life, health or annuity contract;

(xxi) "Unallocated annuity contract" means an annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate;

(xxii) "Enrollee" means an individual who is enrolled in a health maintenance organization;

(xxiii) "Health benefit plan" means any hospital or medical expense policy or certificate, or health maintenance organization subscriber contract or any other similar health contract. "Health benefit plan" does not include any of the following:

(A) Accident only insurance;

(B) Credit insurance;

(C) Dental only insurance;

(D) Vision only insurance;

(E) Medicare supplement insurance;

(F) Benefits for long term care, home health care, community based care or any combination thereof;

(G) Disability income insurance;

(H) Coverage for on-site medical clinics;

(J) Specified disease, hospital confinement indemnity or limited benefit health issuance if the types of coverage do not provide coordination of benefits and are provided under separate policies or certificates.

(xxiv) "This act" means W.S. 26-42-101 through 26-42-118.

26-42-103. Coverage and limitations.

(a) This act shall provide coverage for the policies and contracts specified in subsection (b) of this section and provide coverage as follows:

(i) To persons who are owners, certificate holders or enrollees under the policies or contracts other than structured settlement annuities and in each case who:

(A) Are residents; or

(B) Are not residents but only under all of the following conditions:

(I) The member insurer that issued the policies or contracts is domiciled in this state;

(II) The states in which the persons reside have associations similar to the association created by this act; and

(III) The persons are not eligible for coverage by an association in any other state due to the fact that the insurer or health maintenance organization was not licensed in the state at the time specified in the state's guaranty association law.

(ii) To persons who are the beneficiaries, assignees or payees of the persons described in paragraph (a)(i) of this section, including health care providers rendering services covered under health insurance policies or certificates, regardless of where they reside except for nonresident certificate holders under group policies or contracts;

(iii) For structured settlement annuities specified in subsection (b) of this section, paragraphs (i) and (ii) of this subsection shall not apply, and this act shall, except as provided in paragraphs (iv) and (v) of this subsection, provide coverage to a person who is a payee under a structured settlement annuity or beneficiary of a payee if the payee is deceased, if the payee:

(A) Is a resident, regardless of where the contract owner resides; or

(B) Is not a resident, but only under both of the following conditions:

(I) The contract owner of the structured settlement annuity is a resident, or the contract owner of the structured settlement annuity is not a resident, but the insurer that issued the structured settlement annuity is domiciled in this state and the state in which the contract owner resides has an association similar to the association created by this act; and

(II) Neither the payee or beneficiary of the contract owner nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides.

(iv) This act shall not provide coverage to:

(A) A person who is a payee or beneficiary of a contract owner resident of this state, if the payee or beneficiary is afforded any coverage by the association of another state; or

(B) A person who acquires rights to receive payments through a structured settlement factoring transaction as defined in 26 U.S.C. §5891(c)(3)(A), regardless if the transaction occurred before or after 26 U.S.C. § 5891(c)(3)(A) became effective.

(v) This act is intended to provide coverage to a person who is a resident of this state and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this act is provided coverage under the laws of any other state, the person shall not be provided coverage under this act. In determining the application of the provisions of this paragraph in situations where a person could be covered by the association of more than one (1) state, whether as an owner, payee, enrollee, beneficiary or assignee, this act shall be construed in conjunction with other state laws to result in coverage by only one (1) association.

(b) This act shall provide coverage to persons specified in subsection (a) of this section for policies or contracts of direct, nongroup life insurance, health insurance including health maintenance organization subscriber contracts and certificates, annuities and supplemental contracts to any of

these policies or contracts and for certificates under direct group policies and contracts issued by member insurers except as limited by this act. Annuity contracts and certificates under group annuity contracts include allocated funding agreements, structured settlement annuities and any immediate or deferred annuity contracts.

(c) This act shall not provide coverage for:

(i) Any portion of a policy or contract not guaranteed by the insurer or under which the risk is borne by the policyholder or contract holder;

(ii) Any policy or contract of reinsurance unless assumption certificates have been issued pursuant to the reinsurance policy or contract;

(iii) Excluding any portion of a policy or contract, including a rider, that provides long term care or other health insurance benefits, any portion of a policy or contract to the extent that the rate of interest on which it is based:

(A) Averaged over the period of four (4) years prior to the date on which the member insurer becomes an impaired or insolvent insurer under this act, exceeds a rate of interest determined by subtracting two (2) percentage points from Moody's Corporate Bond Yield Average averaged for that same four (4) year period or for a lesser period if the policy or contract was issued less than four (4) years before the member insurer becomes an impaired or insolvent insurer under this act; and

(B) On and after the date on which the member insurer becomes an impaired or insolvent insurer under this act, exceeds the rate of interest determined by subtracting three (3) percentage points from the most recent and available Moody's Corporate Bond Yield Average.

(iv) Any portion of a policy or contract issued to a plan or program of an employer, association or other person to provide life, health or annuity benefits to its employees, members or others to the extent that the plan or program is self-funded or uninsured, including but not limited to benefits payable by an employer, association or similar entity under:

(A) A multiple employer welfare arrangement as defined in Section 3(40) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1002(40);

(B) A minimum premium group insurance plan;

(C) A stop-loss group insurance plan; or

(D) An administrative services only contract.

(v) Any portion of a policy or contract to the extent it provides dividends or experience rating credits, voting rights or provides payment of any fees or allowances to any person, including the policyholder or contract holder, in connection with the service to or administration of the policy or contract;

(vi) Any policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue the policy or contract in this state;

(vii) Any annuity contract or group annuity certificate which is not issued to and not owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate;

(viii) Any annuity contract or group annuity certificate which is issued by a nonprofit insurance company exclusively for the benefit of nonprofit educational institutions and their employees for the purpose of providing retirement benefits;

(ix) A portion of a policy or contract to the extent that the assessments required by W.S. 26-42-107 with respect to the policy or contract are preempted or otherwise not permitted by federal or state law;

(x) An obligation that does not arise under the express written terms of the policy or contract issued by the member insurer to the enrollee, certificate holder, contract owner or policy owner, including without limitation:

(A) Claims based on marketing materials;

(B) Claims based on side letters, riders or other documents that were issued by the member insurer without meeting applicable policy or contract form filing or approval requirements;

(C) Misrepresentations of or regarding policy or contract benefits;

(D) Extra-contractual claims; or

(E) A claim for penalties or consequential or incidental damages.

(xi) A contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer;

(xii) An unallocated annuity contract;

(xiii) A policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Part C or Part D of Subchapter XVIII, Chapter 7 of Title 42 of the United States Code (commonly known as Medicare Part C & D) or Subchapter XIX, Chapter 7 of Title 42 of the United States Code (commonly known as Medicaid) or any regulations issued pursuant thereto;

(xiv) A portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under this act, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this provision, the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and will not be subject to forfeiture;

(xv) Structured settlement annuity benefits to which a payee or beneficiary has transferred his rights in a structured settlement factoring transaction as defined in 26 U.S.C. § 5891(c)(3)(A), regardless if the transaction occurred before or after 26 U.S.C. § 5891(c)(3)(A) became effective.

(d) The benefits for which the association may be liable shall in no event exceed the lesser of:

(i) The contractual obligations for which the member insurer is liable or would have been liable if it was not an impaired or insolvent insurer; or

(ii) With respect to any one (1) life, regardless of the number of policies or contracts:

(A) Three hundred thousand dollars ($300,000.00) in life insurance death benefits but not more than one hundred thousand dollars ($100,000.00) in net cash surrender and net cash withdrawal values for life insurance;

(B) For health insurance benefits:

(I) One hundred thousand dollars ($100,000.00) for coverages not defined as disability insurance, disability income insurance, health benefit plan or long term care insurance including any net cash surrender and net cash withdrawal values;

(II) Three hundred thousand dollars ($300,000.00) for disability insurance, disability income insurance and long-term care insurance;

(III) Three hundred thousand dollars ($300,000.00) for health benefit plans.

(C) Two hundred fifty thousand dollars ($250,000.00) in the present value of annuity benefits including net cash surrender and net cash withdrawal values;

(D) With respect to each payee of a structured settlement annuity or beneficiary or beneficiaries of the payee if deceased, two hundred fifty thousand dollars ($250,000.00) in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values;

(E) However, in no event shall the association be obligated to cover more than:

(I) An aggregate of five hundred thousand dollars ($500,000.00) in benefits with respect to any one (1) life under paragraphs (A) through (D) of this subsection; or

(II) With respect to one (1) owner of multiple nongroup policies of life insurance, whether the policy owner or contract owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, more than five million dollars ($5,000,000.00) in benefits, regardless of the number of policies and contracts held by the owner.

(F) The limitations set forth in this subsection are limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations under this act may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights;

(G) For purposes of this act, benefits provided by a long term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

(e) The liability of the association is strictly limited by the express terms of the covered policies and contracts and by the provisions of this act and is not affected by the contents of any brochures, illustrations, advertisements or oral statements by agents, brokers or others used or made in connection with their sale. The association is not liable for any extracontractual, exemplary or punitive damages, attorney's fees or interest other than as provided for by the terms of such policies or contracts, as limited by this act.

(f) Repealed By Laws 2014, Ch. 21, § 2.

(g) In performing its obligations to provide coverage under W.S. 26-42-106, the association shall not be required to guarantee, assume, reinsure, reissue or perform, or cause to be guaranteed, assumed, reinsured, reissued or performed, the

contractual obligations of the insolvent or impaired insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

26-42-104. Creation of the association.

(a) There is created a nonprofit legal entity to be known as the Wyoming life and health insurance guaranty association. All member insurers are members of the association as a condition of their authority to transact insurance or health maintenance organization business in this state. The association shall perform its functions under the plan of operation established and approved under W.S. 26-42-108 and shall exercise its powers through a board of directors provided by W.S. 26-42-105. For purposes of administration and assessment the association shall maintain the three (3) following accounts:

(i) The life insurance account;

(ii) The health account; and

(iii) The annuity account.

(b) The association is under the supervision of the commissioner and is subject to the applicable provisions of the insurance laws of this state. Meetings or records of the association may be opened to the public upon majority vote of the board of directors of the association.

26-42-105. Board of directors.

(a) The board of directors of the association consists of not less than five (5) nor more than nine (9) member insurers serving terms as established in the plan of operation provided by W.S. 26-42-108. Membership on the board shall be subject to the following:

(i) The members of the board shall be selected by member insurers subject to the approval of the commissioner;

(ii) A majority of the members shall be domestic insurers. If there are not enough domestic insurers for a majority, then all domestic insurers shall be on the board. The domestic insurers shall hold the positions of chairman and at least one (1) other officer position on the board if possible;

(iii) Each member insurer selected shall identify the individual representing the member insurer on the board and shall provide the individual's name, address, biographical information and position in an affidavit to the commissioner for review and approval;

(iv) Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining board members subject to the approval of the commissioner.

(b) In approving selections or in appointing members to the board, the commissioner shall consider, among other factors, whether all member insurers are fairly represented.

(c) Members of the board shall be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors. Members of the board shall not otherwise be compensated by the association for their services.

26-42-106. Powers and duties of the association.

(a) If a member insurer is an impaired insurer, the association may in its discretion and subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer, that are approved by the commissioner:

(i) Guarantee, assume, reissue or reinsure or cause to be guaranteed, assumed, reissued or reinsured any or all of the policies or contracts of the impaired insurer;

(ii) Provide monies, pledges, loans, notes, guarantees, or other means proper to effectuate this subsection and assure payment of the contractual obligations of the impaired insurer pending action taken as authorized by this subsection.

(iii) Repealed By Laws 2014, Ch. 21, § 2.

(b) Repealed By Laws 2014, Ch. 16, § 2.

(c) Repealed By Laws 2014, Ch. 16, § 2.

(d) If a member insurer is an insolvent insurer, the association shall, in its discretion, do one (1) of the following:

(i) Guaranty, assume, reissue or reinsure or cause to be guaranteed, assumed, reissued or reinsured, the policies or contracts of the insolvent insurer and provide monies, pledges, guarantees or other means as reasonably necessary to discharge the duties;

(ii) Assure payment of the contractual obligations of the insolvent insurer and provide monies, pledges, guarantees or other means as reasonably necessary to discharge the duties;

(iii) With respect to life and health insurance policies and annuities, provide benefits and coverages in accordance with subsection (e) of this section; or

(iv) With respect to health benefit plans that are subject to state or federal guaranteed issue requirements, terminate the policies no later than sixty (60) days after the entry of an order of liquidation with the approval of the commissioner.

(e) With respect to policies and contracts and when proceeding under paragraph (d)(iii) of this section, the association:

(i) Shall assure payment of benefits that would have been payable under the policies or contracts of the insolvent insurer for claims incurred:

(ii) Shall make diligent efforts to provide all known insureds, enrollees or annuitants for nongroup policies and contracts, or group policy owners or contracts owners with respect to group policies and contracts, thirty (30) days notice of the termination of the benefits provided;

(iii) For nongroup policies and contracts covered by the association, shall make available to each known insured, enrollee or annuitant, or owner if other than the insured or annuitant and with respect to an individual formerly an insured, enrollee or annuitant under a group policy or contract who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of paragraph (iv) of this subsection, if the insureds, enrollees or annuitants had a right under law or the terminated policy, contract or annuity to convert coverage to individual coverage or to continue an individual policy, contract or annuity in force until a specified age or for a

specified time during which the insurer or health maintenance organization had no right unilaterally to make changes in any provisions of the policy, contract or annuity or had a right only to make changes in premium by class;

(iv) In providing the substitute coverage required under paragraph (iii) of this subsection, may offer either to reissue the terminated coverage or to issue an alternative policy or contract at actuarially justified rates subject to the prior approval of the commissioner. Alternative or reissued policies or contracts shall be offered without requiring evidence of insurability and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy or contract. The association may reinsure any alternative or reissued policy or contract;

(v) May adopt alternative policies or contracts of various types for future issuance without regard to any particular impairment or insolvency. The alternative policies:

(A) Are subject to the approval of the commissioner;

(B) Shall contain at least the minimum statutory provisions required in this state and provide benefits that are not unreasonable in relation to the premium charged;

(C) Shall have premiums set by the association in accordance with a table of rates which it adopts and which reflect the amount of insurance to be provided and the age and class of risk of each insured but do not reflect any changes in the health of the insured after the original policy or contract was last underwritten;

(D) Shall provide coverage of a type similar to that of the policy or contract issued by the impaired or insolvent insurer, as determined by the association.

(vi) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy or contract, shall set the premium at actuarially justified rates and in accordance with the amount of insurance or coverage provided and the age and class of risk, subject to prior approval of the commissioner or a court of competent jurisdiction; and

(vii) With respect to coverage under any policy or contract of the impaired or insolvent insurer or under any reissued or alternative policy or contract, shall have its obligations cease on the date coverage or the policy or contract is replaced by another similar policy or contract by the policy owner or contract owner, the insured, the enrollee or the association.

(f) When proceeding under subsection (d) of this section with respect to any policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with W.S. 26-42-103(c)(iii).

(g) Nonpayment of premiums within thirty-one (31) days after the date required under the terms of any guaranteed, assumed, alternative or reissued policy or contract or substitute coverage shall terminate the association's obligations under the policy, contract or coverage incurred pursuant to this act, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of this act.

(h) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer belongs to and is payable at the direction of the association, and the association is liable for unearned premiums due to policy or contract owners arising after the entry of the order.

(j) The protection provided by this act shall not apply where any guaranty protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state.

(k) In carrying out its duties under subsection (d) of this section the association may, subject to approval by a court of competent jurisdiction:

(i) Impose permanent policy or contract liens in connection with any guarantee, assumption or reinsurance agreement, if the association finds that the amounts which may be assessed under this act are less than the amounts needed to assure full and prompt performance of the association's duties under this act or that the economic or financial conditions as they affect member insurers are sufficiently adverse that it is within the public interest to render the imposition of the permanent policy or contract liens;

(ii) Impose temporary moratoriums or liens on payments of cash values and policy loans or any other right to withdraw funds held in conjunction with policies or contracts in addition to any contractual provisions for deferral of cash or policy loan value. In addition, in the event of a temporary moratorium or moratorium charge imposed by the receivership court on payment of cash values or policy loans, or on any other right to withdraw funds held in conjunction with policies or contracts, out of the assets of the impaired or insolvent insurer, the association may defer the payment of cash values, policy loans or other rights by the association for the period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

(m) A deposit in this state, held pursuant to law or required by the commissioner for the benefit of creditors, including policy owners or contract owners, not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of a member insurer domiciled in this state or in a reciprocal state shall be promptly paid to the association. The association shall be entitled to retain a portion of any amount so paid to it equal to the percentage determined by dividing the aggregate amount of policy owners' or contract owners' claims related to that insolvency for which the association has provided statutory benefits by the aggregate amount of all policy owners' or contract owners' claims in this state related to that insolvency and shall remit to the domiciliary receiver the amount so paid to the association less the amount retained pursuant to this subsection. Any amount so paid to the association and retained by it shall be treated as a distribution of estate assets pursuant to applicable state receivership law dealing with early access disbursements.

(n) If the association fails to act within a reasonable period of time as provided in subsections (d) and (e) of this section, the commissioner shall have the powers and duties of the association under this act with respect to insolvent insurers.

(o) The association may render assistance and advice to the commissioner upon his request concerning rehabilitation, payment of claims, continuance of coverage or the performance of

other contractual obligations of any impaired or insolvent insurer.

(p) The association shall have standing to appear before any court or agency in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this act or with jurisdiction over any person or property against which the association may have rights through subrogation or otherwise. Standing shall extend to all matters germane to the powers and duties of the association, including but not limited to, proposals for reinsuring, reissuing, modifying or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The association shall also have the right to appear or intervene before a court or agency in any state with jurisdiction over an impaired or insolvent insurer if the association is or may become obligated or with jurisdiction over any person or property against whom the association may have rights through subrogation or otherwise.

(q) Any person receiving benefits under this act shall be deemed to have assigned the rights under and any causes of action against any person for losses arising under, resulting from or otherwise relating to the covered policy or contract to the association to the extent of the benefits received because of this act, whether the benefits are payments of or on account of contractual obligations, continuation of coverage or provision of substitute or alternative policies, contracts or coverages. The association may require an assignment to it of the rights and cause of action by any enrollee, payee, policy or contract owner, beneficiary, insured or annuitant as a condition precedent to the receipt of any right or benefits conferred by this act upon the person. The subrogation rights of the association under this subsection shall have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this act. In addition, the association shall have all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary, enrollee or payee of a policy or contract with respect to the policy or contracts and shall include, in the case of a structured settlement annuity, any rights of the owner, beneficiary or payee of the annuity, to the extent of benefits received pursuant to this act, against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or

payment therefor, excluding any person responsible solely by reason of serving as an assignee in respect to a qualified assignment under section 130 of the Internal Revenue Code. If the provisions of this subsection are invalid or ineffective with respect to any person or claim for any reason, the amount payable by the association with respect to the related covered obligations shall be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies or portion thereof covered by the association. If the association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the association has rights as described in this subsection, the person shall pay to the association the portion of the recovery attributable to the policies or portion thereof covered by the association.

(r) The association may:

(i) Enter into contracts as necessary or proper to carry out the provisions and purposes of this act;

(ii) Sue or be sued including taking any legal actions necessary or proper to recover any unpaid assessments under W.S. 26-42-107 and to settle claims or potential claims against it;

(iii) 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 member insurers and may be carried as admitted assets;

(iv) Employ or retain persons as necessary to handle the financial transactions of the association and to perform other functions as necessary or proper under this act;

(v) Take legal action as necessary or appropriate to avoid or recover payment of improper claims;

(vi) Exercise, for the purposes of this act and to the extent approved by the commissioner, the powers of a domestic life insurer, health maintenance organization or health insurer. The association shall not issue policies or contracts other than those issued to perform its obligations under this act;

(vii) Organize itself as a corporation or in other legal form permitted by the laws of the state;

(viii) Request information from a person seeking coverage from the association in order to aid the association in determining its obligations under this act with respect to the person, and the person shall promptly comply with the request;

(ix) Unless prohibited by law, in accordance with the terms and conditions of the policy or contract, file for actuarially justified rate or premium increases for any policy or contract for which it provides coverage under this act;

(x) Take other necessary or appropriate action to discharge its duties and obligations under this act or to exercise its powers under this act.

(s) The association may join an organization of one (1) or more other state associations of similar purposes to further the purposes and administer the powers and duties of the association.

(t) With respect to covered policies or contracts for which the association becomes obligated after an entry of an order of liquidation or rehabilitation, the association may elect to succeed to the rights of the insolvent insurer arising after the date of the order of liquidation or rehabilitation under any contract of reinsurance to which the insolvent insurer was a party, to the extent that the contract provides coverage for losses occurring after the date of the order of liquidation or rehabilitation. As a condition to making this election, the association shall pay all unpaid premiums due under the contract for coverage relating to periods before and after the date of the order of liquidation or rehabilitation.

(u) The board of directors of the association shall have discretion and may exercise reasonable business judgment to determine the means by which the association is to provide the benefits of this act in an economical and efficient manner.

(w) Where the association has arranged or offered to provide the benefits of this act to a covered person under a plan or arrangement that fulfills the association's obligations under this act, the person shall not be entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.

(y) The association shall not be required to give an appeal bond in an appeal that relates to a cause of action arising under this act.

(z) In carrying out its duties in connection with guaranteeing, assuming, reissuing or reinsuring policies or contracts under subsection (a) or (d) of this section, the association may, subject to approval of the commissioner, issue substitute coverage for a policy or contract that provides an interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with the following provisions:

(i) In lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for a fixed interest rate, payment of dividends with minimum guarantees or a different method for calculating interest or changes in value;

(ii) There is no requirement for evidence of insurability, waiting period or other exclusion that would not have applied under the replaced policy or contract; and

(iii) The alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms.

26-42-107. Assessments.

(a) 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 and at a time and for amounts as the board finds necessary. Assessments are due not less than thirty (30) days after prior written notice to the member insurers and shall accrue interest at the rate set by 28 U.S.C. § 1961 on and after the due date.

(b) There shall be two (2) assessments as follows:

(i) Class A assessments shall be authorized and called to pay administrative and legal costs and other expenses and examinations conducted under the authority of W.S. 26-42-110(e). Class A assessments may be authorized and called

whether or not related to a particular impaired or insolvent insurer;

(ii) Class B assessments shall be authorized and called as necessary to carry out the powers and duties of the association under W.S. 26-42-106 with regard to an impaired or an insolvent insurer.

(c) The amount of any Class A assessment shall be determined at the discretion of the board of directors and those assessments may be authorized and called on a non pro rata basis. The amount of any Class B assessment shall be allocated for assessment purposes among the accounts pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board in its sole discretion as fair and reasonable under the circumstances.

(d) Class B assessments against member insurers for each account shall be in the proportion that the premiums received on business in this state by each assessed member insurer or policies or contracts covered by each account for the three (3) most recent calendar years for which information is available preceding the year in which the insurer became insolvent, or in the case of an assessment with respect to an impaired insurer, the three (3) most recent calendar years for which information is available preceding the year in which the insurer became impaired, bears to the premiums received on business in this state for the calendar years by all assessed member insurers. The amount of the Class B assessment for long term care insurance written by the impaired or insolvent insurer shall be allocated according to a methodology included in the plan of operation and approved by the commissioner. The methodology shall provide for fifty percent (50%) of the assessment to be allocated to accident and health member insurers and fifty percent (50%) to be allocated to life and annuity member insurers.

(e) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer shall not be made until necessary to implement the purposes of this act. Classification of assessments under subsection (b) of this section and computation of assessments under subsections (c) and (d) of this section shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The association shall notify each member insurer of its anticipated pro-rata share of an

authorized assessment not yet called within one hundred eighty (180) days after the assessment is authorized.

(f) 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. In the event 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. Once the conditions that caused a deferral have been removed or rectified, the member insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the association.

(g) The total of all assessments imposed upon a member insurer for each account are subject to the following:

(i) Subject to paragraph (ii) of this subsection, the total of all assessments authorized by the association with respect to a member insurer for each account shall not in any one (1) calendar year exceed two percent (2%) of the insurer's average premiums received in this state on the policies and contracts covered by the account during the three (3) calendar years preceding the year in which the member insurer became an impaired or insolvent insurer;

(ii) If two (2) or more assessments are authorized in one (1) calendar year with respect to member insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation referenced in paragraph (i) of this subsection shall be equal and limited to the higher of the three (3) year average annual premiums for the applicable subaccount or account as calculated pursuant to this subsection;

(iii) If the maximum assessment including the other assets of the association in any account does not provide in any one (1) year in either account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon thereafter as permitted by this act;

(iv) The board may provide in the plan of operation provided by W.S. 26-42-108 a method of allocating funds among claims, whether relating to one (1) or more impaired or

insolvent insurers when the maximum assessment will be insufficient to cover anticipated claims.

(h) The board may refund to member insurers 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 the account, including assets accruing from assignment, subrogation, net realized gains and income from investments. The board shall use an equitable method to make the refunds and the refunds shall be in proportion to the contribution of each member insurer to the account. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the association and for future losses.

(j) Any member insurer may, in determining its premium rates and policy owner dividends as to any kind of insurance or health maintenance organization business within the scope of this act, consider the amount reasonably necessary to meet its assessment obligations under this act.

(k) The association shall issue to each member 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 shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the member insurer in its financial statement as an asset in a form and for an amount, if any, and a period of time as approved by the commissioner.

(m) A member insurer that wishes to protest all or part of an assessment shall pay when due the full amount of the assessment as set forth in the notice provided by the association. The payment shall be available to meet association obligations during the pendency of the protest or any subsequent appeal. Payment shall be accompanied by a statement in writing that the payment is made under protest and setting forth a brief statement of the grounds for the protest. Within sixty (60) days following the payment of an assessment under protest by a member insurer, the association shall notify the member insurer in writing of its determination with respect to the protest unless the association notifies the member insurer that additional time is required to resolve the issues raised by the protest. Within thirty (30) days after a final decision has been made, the association shall notify the protesting member insurer in writing of that final decision. Within sixty (60) days of

receipt of notice of the final decision, the protesting member insurer may appeal that final action to the commissioner. In the alternative to rendering a final decision with respect to a protest based on a question regarding the assessment base, the association may refer protests to the commissioner for a final decision, with or without a recommendation from the association. If the protest or appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member insurer. Interest on a refund due a protesting member insurer shall be paid at the rate actually earned by the association.

(n) The association may request information of member insurers in order to aid in the exercise of its power under this section and member insurers shall promptly comply with a request.

26-42-108. Plan of operation.

(a) The association shall maintain a plan of operation to assure the fair, reasonable and equitable administration of the association. The plan of operation and any amendments to the plan of operation shall be submitted to the commissioner and are effective upon the commissioner's written approval or after thirty (30) days if he has not disapproved them.

(b) If the association fails to submit a suitable plan of operation or suitable amendments to the plan, the commissioner shall after notice and hearing adopt and promulgate reasonable rules as necessary or advisable to implement the provisions of this act. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

(c) All member insurers shall comply with the plan of operation.

(d) The plan of operation shall, in addition to requirements enumerated in other provisions of this act:

(i) Establish procedures for handling the assets of the association;

(ii) Establish the amount and method of reimbursing members of the board of directors under W.S. 26-42-105;

(iii) Establish regular places and times for meetings including telephone conference calls of the board of directors;

(iv) Establish procedures for records to be kept of all financial transactions of the association, the association's agents and the board of directors;

(v) Establish the procedures for making selections for the board of directors and submitting them to the commissioner;

(vi) Establish any additional procedures for assessments under W.S. 26-42-107;

(vii) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

(e) The plan of operation may provide that any or all powers and duties of the association, except those under W.S. 26-42-106(p) and 26-42-107, are delegated to a corporation, association or other organization which performs or will perform functions similar to those of the association or its equivalent in two (2) or more states. The corporation, association or organization shall be reimbursed for any payments made on behalf of the association and shall be paid for its performance of any function of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the commissioner and may be made only to a corporation, association or organization which extends protection similar to that provided by this act.

26-42-109. Duties and powers of the commissioner.

(a) In addition to the duties and powers enumerated in other provisions of this act, the commissioner shall:

(i) Upon request of the board of directors, provide the association with a statement of the premiums in this and any other appropriate state for each member insurer;

(ii) When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to eliminate the impairment within a reasonable time. Notice to the impaired insurer shall constitute notice to its shareholders, if any. The failure of the impaired insurer to promptly comply with the demand shall not excuse the association from the performance of its powers and duties under this act;

(iii) In any liquidation or rehabilitation proceeding involving a domestic insurer, be appointed as the liquidator, rehabilitator or conservator.

(b) The commissioner may suspend or revoke after notice and hearing the certificate of authority to transact business in this state of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative the commissioner may levy a forfeiture on any member insurer which fails to pay an assessment when due. Such forfeiture shall not exceed five percent (5%) of the unpaid assessment per month, but no forfeiture shall be less than one hundred dollars ($100.00) per month.

(c) Any action of the board of directors or the association may be appealed to the commissioner by any member insurer if an appeal is taken within sixty (60) days of the final action being appealed. Any final action or order of the commissioner is subject to judicial review in a court of competent jurisdiction.

(d) The liquidator, rehabilitator or conservator of any impaired insurer may notify all interested persons of the effect of this act.

26-42-110. Prevention of insolvencies.

(a) To aid in the detection and prevention of member insurer insolvencies or impairments, the commissioner shall:

(i) Notify the commissioners of all the other states, territories of the United States and the District of Columbia by mail within thirty (30) days of any of the following actions taken against a member insurer:

(A) Revocation of license;

(B) Suspension of license; or

(C) Issuance of any formal order requiring the member insurer to:

(I) Restrict its premium writing;

(II) Obtain additional contributions to surplus;

(III) Withdraw from the state;

(IV) Reinsure all or any part of its business; or

(V) Increase capital, surplus or any other account for the security of policy owners, contract owners, certificate holders or creditors.

(ii) Report to the board of directors when he has taken any actions provided by paragraph (i) of this subsection or has received a report from any other commissioner indicating that any action provided by paragraph (i) of this subsection has been taken in another state. The report to the board of directors shall contain all significant details of the action taken or the report received from another commissioner;

(iii) Report to the board of directors when he has reasonable cause to believe from any completed or pending examination of any member company that the company may be an impaired or insolvent insurer;

(iv) Furnish to the board of directors the national association of insurance commissioners insurance regulatory information system ratios and listings of companies not included in the ratios developed by the national association of insurance commissioners, and the board may use this information in carrying out its duties and responsibilities under this section. The report and its information shall be kept confidential by the board of directors until the commissioner or other lawful authority makes it a public record.

(b) The commissioner may seek the advice and recommendations of the board of directors concerning any matter affecting his duties and responsibilities regarding the financial condition of member insurers and insurers or health maintenance organizations seeking admission to transact business in this state.

(c) The board of directors may by majority vote make reports and recommendations to the commissioner upon any matter germane to the solvency, liquidation, rehabilitation or conservation of any member insurer or germane to the solvency of any insurers or health maintenance organizations seeking to do any business in this state. The reports and recommendations are confidential and shall not be considered public documents.

(d) It is the duty of the board of directors by majority vote to notify the commissioner of any information indicating any member insurer may be an impaired or insolvent insurer.

(e) The board of directors may by 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 (30) days of the receipt of a request, the commissioner shall begin an examination. The examination may be conducted as a national association of insurance commissioners examination or may be conducted by persons designated by the commissioner. The cost of the examination shall be paid by the association and the examination report shall be treated the same as other examination reports. In no event shall the examination report be released to the board of directors prior to its release to the public, but this shall not preclude the commissioner from complying with subsection (a) of this section. 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 shall not be open to public inspection prior to the release of the examination report to the public.

(f) The board of directors may by majority vote make recommendations to the commissioner for the detection and prevention of member insurer insolvencies.

(g) 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 information it has 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 of insolvency of a particular insurer and may adopt by reference any report prepared by other associations.

26-42-111. Credits for assessments paid; tax offsets.

(a) A member insurer may offset against its premium tax liability to this state an assessment described in W.S. 26-42-107(k) to the extent of ten percent (10%) of the amount of the assessment for each of the ten (10) 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 tax liability for the year it ceases doing business.

(b) Any sums which are acquired by refund pursuant to W.S. 26-42-107(h) from the association by member insurers and which have been offset against premium taxes as provided in subsection (a) of this section, shall be paid by the member insurers to this state as required by the commissioner. The association shall notify the commissioner that the refunds have been made.

26-42-112. Assessment liability; records; assets; proceedings against impaired or insolvent insurer.

(a) This act shall not be construed to reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

(b) Records shall be kept of all meetings in which the board of directors discuss the activities of the association in carrying out its powers and duties under W.S. 26-42-106. The records of the association with respect to an impaired or insolvent insurer shall not be disclosed prior to the termination of a liquidation, rehabilitation or conservation proceeding involving the impaired or insolvent insurer except upon the termination of the impairment or insolvency of the insurer or upon the order of a court of competent jurisdiction. Nothing in this subsection shall limit the duty of the association to render a report of its activities under W.S. 26-42-113.

(c) 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 or contracts reduced by any amounts to which the association is entitled as assignee or subrogee pursuant to W.S. 26-42-106(q). Assets of the impaired or insolvent insurer attributable to covered policies or contracts shall be used to continue all covered policies or contracts and pay all contractual obligations of the impaired or insolvent insurer as required by this act. As used in this subsection, "assets attributable to covered policies or contracts" means that proportion of the assets which the reserves that should have been established for such policies or contracts bear to the reserves that should have been established for all policies or contracts of insurance or health benefits plans written by the impaired or insolvent insurer.

(d) Prior to the termination of any liquidation, rehabilitation or conservation proceeding the court may consider the contributions of the respective parties including the association, the shareholders, contract owners, certificate holders, enrollees and policy owners of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of the insolvent insurer. In such a determination consideration shall be given to the welfare of the owners, contract owners, certificate holders and enrollees of the continuing or successor insurer. No distribution to stockholders, if any, of an impaired or insolvent insurer shall be made until and unless the total amount of valid claims and interest on the claims of the association for funds expended in carrying out its powers and duties under W.S. 26-42-106 with respect to the member insurer have been fully recovered by the association.

(e) If an order for liquidation or rehabilitation of a member insurer domiciled in this state is entered, the receiver appointed under the order shall have a right to recover on behalf of the member insurer from any affiliate that controlled it, the amount of distributions other than stock dividends paid by the member insurer on its capital stock, made at any time during the five (5) years preceding the petition for liquidation or rehabilitation subject to the limitations of subsections (f), (g) and (h) of this section.

(f) No distribution pursuant to subsection (e) of this section is recoverable if the member insurer shows that when paid the distribution was lawful and reasonable and that the member insurer did not know and could not reasonably have known the distribution might adversely affect the ability of the member insurer to fulfill its contractual obligations.

(g) Any person who was an affiliate that controlled the member insurer at the time the distributions were paid is liable up to the amount of distributions he received. Any person who was an affiliate that controlled the member insurer at the time the distributions were declared is liable up to the amount of distributions he would have received if they had been paid immediately. If two (2) or more persons are liable with respect to the same distributions they are jointly and severally liable.

(h) The maximum amount recoverable under subsections (e) through (g) of this section is the amount needed in excess of

all other available assets of the insolvent insurer to pay the contractual obligations of the insolvent insurer.

(j) If any person liable under subsection (g) of this section is insolvent, all its affiliates that controlled it at the time the distribution was paid are jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

(k) As a creditor of the impaired or insolvent insurer as established in subsection (c) of this section, the association and other similar associations shall be entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the assets become available to reimburse it, as a credit against contractual obligations under this act. If the liquidator has not, within one hundred twenty (120) days of a final determination of insolvency of a member insurer by the receivership court, made an application to the court for the approval of a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvency, then the association shall be entitled to make application to the receivership court for approval of its own proposal to disburse these assets.

26-42-113. Examination of the association; annual report.

The association is subject to examination and regulation by the commissioner. The board of directors shall submit to the commissioner each year not later than one hundred twenty (120) days after the association's fiscal year, a financial report in a form approved by the commissioner and a report of its activities during the preceding fiscal year.

26-42-114. 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.

26-42-115. Stay of proceedings; reopening default judgments.

All proceedings in which the insolvent insurer is a party in any court in this state shall be stayed one hundred eighty (180) 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 the suit on the merits.

26-42-116. Prohibited advertisement of association chapter in insurance sales; notice.

(a) No person including a member insurer, agent or affiliate of an insurer shall 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, in the form of a notice, circular, pamphlet, letter or poster, over any radio station or television station, or in any other way, any advertisement, announcement or written or oral statement which uses the existence of the association of this state for the purpose of sales, solicitation or inducement to purchase any form of insurance or other coverage covered by this act. This subsection shall not apply to the association or any other entity which does not sell or solicit insurance or health maintenance organization coverage.

(b) Within one hundred eighty (180) days of the effective date of this act, the association shall prepare a summary document describing the general purposes and current limitations of the act and complying with subsection (c) of this section and submit it to the commissioner for approval. Sixty (60) days after receiving approval, no member insurer may deliver a policy or contract described in W.S. 26-42-103(b) to a policy owner, contract owner, certificate holder or enrollee unless the document provided in subsections (b) and (c) of this section is delivered to the policy owner, contract owner, certificate holder or enrollee prior to or at the time of delivery of the policy or contract except if subsection (d) of this section applies. The document shall be available upon request by a policy owner, contract owner, certificate holder or enrollee. The distribution, delivery or contents or interpretation of the document shall not mean that either the policy or the contract or the policy owner, contract owner, certificate holder or enrollee would be covered in the event of impairment or insolvency of a member insurer. The description document shall be revised by the association as required by this act. Failure to receive the document does not give the policy owner, contract owner, certificate holder or enrollee any greater rights than those stated in this act.

(c) The document prepared under subsection (b) of this section shall contain a clear and conspicuous disclaimer on its face. The commissioner shall promulgate a rule establishing the form and content of the disclaimer. The disclaimer shall:

(i) State the name and address of the life and health insurance guaranty association and insurance department;

(ii) Prominently warn the policy owner, contract owner, certificate holder or enrollee that the association may not cover the policy or contract or if coverage is available, it will be subject to substantial limitations and exclusions and conditioned on continued residence in the state;

(iii) State that the member insurer and its agents are prohibited by law from using the existence of the association for the purpose of sales, solicitation or inducement to purchase any form of insurance or health maintenance organization coverage;

(iv) Emphasize that the policy owner, contract owner, certificate holder or enrollee should not rely on coverage under the association when selecting an insurer or health maintenance organization;

(v) Provide other information as directed by the commissioner.

(d) Insurers and agents shall deliver the document and disclaimer described under subsections (b) and (c) of this section when a customer is solicited if a "free look" period is not provided in the policy.

(e) Repealed By Laws 2014, Ch. 21, § 2.

26-42-117. Immunity.

Except as provided by W.S. 26-42-106(r)(ii), 26-42-109(b) and 26-42-112, there shall be no liability on the part of and no cause of action of any nature shall 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 his representatives, for any action or omission by them in the performance of their powers and duties under this act. Immunity shall extend to the participation in any organization of one (1) or more other state associations of

similar purposes and to any such organization and its agents or employees.

26-42-118. Prospective application.

(a) Except as provided in subsection (b) of this section, this act shall apply to any member insurer which is placed under an order of liquidation with a finding of insolvency on or after July 1, 2014.

(b) The amendments provided in the 2014 amendments to W.S. 26-24-103(a) and (d) shall not apply to any member insurer placed under an order of liquidation with a finding of insolvency prior to July 1, 2014.

(c) The amendments provided in the 2019 amendments to this act shall not apply to any member insurer placed under an order of liquidation with a finding of insolvency prior to July 1, 2019.

CHAPTER 43 - HEALTH CARE

ARTICLE 1 - WYOMING HEALTH INSURANCE POOL ACT

26-43-101. Definitions.

(a) As used in this act:

(i) "Account" means the account provided by W.S. 26-43-112;

(ii) "Administrator" means the insurer, insurers or third party administrator or administrators selected pursuant to W.S. 26-43-104(a) to administer the pool;

(iii) "Board" means the board of directors of the pool;

(iv) "Commissioner" means the insurance commissioner;

(v) "Department" means the insurance department;

(vi) "Health insurance" means any public health benefit plan, private health benefit plan, hospital and medical expense incurred policy, Medicare supplement policy, nonprofit health care service plan contract and health maintenance organization subscriber contract. The term does not include any

hospital or medical service plan which by contract or product design is intended to provide coverage for six (6) months or less, fixed indemnity, limited benefit or credit insurance, coverage issued as a supplement to liability insurance, insurance arising from a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance;

(vii) "Health maintenance organization" means as defined by W.S. 26-34-102;

(viii) "Hospital" means a facility licensed as a hospital by the department of health;

(ix) "Insurance arrangement" means any plan, program, contract or any other arrangement under which one (1) or more employers, unions or other organizations provide to their employees or members, either directly or indirectly through a trust or third party administrator, health care services or benefits other than through an insurer. For purposes of assessments under this act "insurance arrangement" does not include any plan, program, contract or other arrangement under which the state of Wyoming, its political subdivisions or school districts provide health care services or benefits pursuant to the authority granted under W.S. 9-3-201;

(x) "Insured" means any individual resident of this state who is eligible to receive benefits from any insurer or insurance arrangement;

(xi) "Insurer" means any insurance company authorized to transact disability insurance business in this state, Medicare supplement insurance issuer, health maintenance organization or health service plan operation under W.S. 26-22-301;

(xii) "Medicare" means coverage under both Part A and B of Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq.;

(xiii) "Member" means all insurers and insurance arrangements participating in the pool;

(xiv) "Plan of operation" means the plan of operation of the pool, including articles, bylaws and operating rules adopted by the board pursuant to W.S. 26-43-102;

(xv) "Pool" means the Wyoming health insurance pool created by W.S. 26-43-102;

(xvi) Repealed by Laws 2019, ch. 16, § 2.

(xvii) "Creditable coverage" means, with respect to an individual, coverage of the individual provided under any private health benefit plan or public health benefit plan;

(xviii) "Federally defined eligible individual" means an individual:

(A) For whom, as of the date on which the individual seeks coverage under this act, the aggregate of the periods of creditable coverage, is eighteen (18) or more months;

(B) Whose most recent prior creditable coverage was under a group private or public health benefit plan;

(C) Who is not eligible for coverage under a group health plan, part A or part B of Medicare or Medicaid, and who does not have other health insurance coverage;

(D) With respect to whom the most recent coverage within the period of aggregate creditable coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;

(E) Who, if offered the option of continuation coverage under a COBRA continuation provision or under a similar state program, elected such coverage; and

(F) Who has exhausted such continuation coverage under such provision or program, if the individual elected the continuation coverage described in subparagraph (E) of this paragraph.

(xix) "Eligibility level" means a percentage of the federal poverty guideline for level of coverage under the plan of operation;

(xx) "This act" means W.S. 26-43-101 through 26-43-114.

26-43-102. Operation of the pool; board membership; board powers and duties.

(a) There is created a nonprofit entity known as the Wyoming health insurance pool. All insurers issuing health insurance in this state and to the extent not preempted by federal law, insurance arrangements providing health plan benefits in this state on and after July 1, 1990, are members of the pool. The commissioner shall give notice to all member insurers and insurance arrangements of the time and place for the initial meeting of the board appointed pursuant to W.S. 26-43-102(b).

(b) The board shall consist of seven (7) members including the commissioner or his designated representative. The commissioner shall appoint three (3) members from participating insurers and three (3) members from the general public. Terms of office for the appointed board members are four (4) years except initial terms shall be less than four (4) years and staggered as determined by the commissioner. The commissioner shall establish procedures for filling vacancies on the board.

(c) Members of the board shall serve without compensation but shall receive travel expenses and per diem from pool funds in the same manner and amount as state employees for services incurred for the board.

(d) The board shall:

(i) Select an administrator of the pool;

(ii) Submit to the commissioner a plan of operation for the pool and any amendments to the plan necessary or suitable to assure the fair, reasonable and equitable administration of the pool. The commissioner shall approve the plan of operation after notice and hearing provided the plan is determined suitable to assure the fair, reasonable and equitable administration of the pool and provides for the sharing of pool gains or losses on an equitable proportionate basis. The plan of operation is effective upon approval in writing by the commissioner. If the board at any time thereafter fails to submit suitable amendments to the plan, the commissioner shall adopt reasonable rules after notice and hearing as necessary or advisable to effectuate the provisions of this section. The rules shall continue in force until modified by the commissioner

or superseded by a plan submitted by the board and approved by the commissioner;

(iii) Have the general powers and authority granted under the laws of this state to insurance companies licensed to transact health insurance;

(iv) Establish for each eligibility level appropriate rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserve formulas and any other actuarial functions appropriate to the operation of the pool. Rates and rate schedules may be adjusted for appropriate risk factors such as age and area variation in claim cost and shall take into consideration appropriate risk factors in accordance with established actuarial and underwriting practices;

(v) Assess members of the pool in accordance with the provisions of this act;

(vi) Issue policies of insurance in accordance with the requirements of this act;

(vii) Repealed by Laws 2019, ch. 16, § 2.

(e) The plan of operation provided by paragraph (d)(ii) of this section shall:

(i) Establish procedures for the handling, investing and accounting of assets and monies of the pool;

(ii) Identify the administrator in accordance with W.S. 26-43-104;

(iii) Establish procedures for the collection of assessments to provide for claims paid under the plan and for administrative expenses incurred or estimated to be incurred during the period for which the assessments are made;

(iv) Establish the level of assessment payments pursuant to W.S. 26-43-105;

(v) Develop and implement a program to publicize and to maintain public awareness of the existence of the plan, the eligibility requirements and procedures for enrollment;

(vi) Establish procedures for termination of pool coverage of any person who ceases to meet the eligibility requirements provided by W.S. 26-43-103;

(vii) Provide as necessary for audits of the pool and the administration of the pool;

(viii) Allow every insurance agent licensed to sell insurance in Wyoming to sell the policy.

(f) The board may:

(i) Enter into contracts as necessary or proper to carry out the provisions and purposes of this act, including but not limited to the authority, with the approval of the insurance commissioner, to enter into contracts with similar pools of other states for the joint performance of common administrative functions or with persons or other organizations for the performance of administrative functions;

(ii) Sue or be sued, including but not limited to taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against pool members;

(iii) Take legal action as necessary to avoid the payment of improper claims against the pool or the coverage provided by or through the pool;

(iv) Appoint from among members appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the pool, policy and other contract design and any other function within the authority of the board;

(v) Repealed by Laws 2019, ch. 16, § 2.

26-43-103. Eligibility.

(a) Except as provided in subsections (b) and (e) of this section, any individual person who is a resident of this state is eligible for pool coverage under eligibility level one (1) or eligibility level two (2) if evidence of the following is provided:

(i) Rejection of or refusal to issue health insurance for health reasons by one insurer;

(ii) Refusal to issue health insurance except at a rate exceeding the applicable pool rate for the coverage applied for under the pool; or

(iii) Refusal to issue health insurance except with a reduction or exclusion of coverage for a preexisting health condition which reduction or exclusion is more restrictive than the reduction or exclusion provided by the applicable pool coverage for which application is being made.

(b) The following persons are not eligible for pool coverage:

(i) Persons who have coverage under health insurance or an insurance arrangement on the issue date of pool coverage;

(ii) Any person who is at the time of pool application eligible for Medicaid health care benefits or any person who is eligible for Medicare by reason of age;

(iii) Any person who terminated coverage in the pool unless twelve (12) months have elapsed from the termination date;

(iv) Any person on whose behalf the pool has paid two hundred fifty thousand dollars ($250,000.00) in benefits. The board shall adjust these amounts annually to reflect the effects of inflation. The adjustment shall not be less than the annual change in the medical component of the "Consumer Price Index for All Urban Consumers" of the department of labor, bureau of statistics, unless the board proposes and the commissioner approves a lower adjustment factor;

(v) Inmates of public institutions;

(vi) Persons who are eligible for group health insurance or a group health insurance arrangement provided in connection with a policy, plan or program sponsored by an employer and subject to regulation as a group health plan under federal or state law, even though the employer coverage is declined, unless:

(A) The cost to insure the individual is offered at a rate to the individual or his employed family member exceeding the applicable pool rate by at least twelve and one-half percent (12.5%) for the coverage applied for under the pool; and

(B) At the time of enrollment, plan enrollment does not exceed ninety-five percent (95%) of maximum enrollment capacity as determined under W.S. 26-43-114.

(c) Repealed by Laws 2019, ch. 16, § 2.

(d) For purposes of catastrophic health insurance pursuant to W.S. 26-43-106(b)(vi), in addition to the requirements of subsection (a) of this section, eligibility shall be limited to those individuals whose total household income does not exceed four hundred percent (400%) of the federal poverty level.

(e) Notwithstanding subsection (a) of this section, the commissioner shall have authority to terminate eligibility and disenroll from coverage under the pool some or all of the individuals who are enrolled in the plan as of July 1, 2015, subject to the following:

(i) The commissioner has determined that all individuals or groups of individuals who are to be disenrolled have reasonable access to health insurance;

(ii) All individuals who are to be disenrolled shall receive prior notice of disenrollment at least ninety (90) days prior to the effective date of the disenrollment;

(iii) The commissioner shall have authority to reenroll any individual or group who were disenrolled pursuant to this subsection if it is demonstrated that the individual or group cannot otherwise be insured at reasonable expense.

26-43-104. Administrator.

(a) The board shall select an insurer, insurers or a third party administrator or administrators through a competitive bidding process to administer the pool. The board shall evaluate bids based on criteria established by the board which shall include but are not limited to:

(i) The proven ability of the administrator to handle individual accident and health insurance;

(ii) The efficiency of the claim paying procedures of the administrator;

(iii) An estimate of total charges for administering the plan;

(iv) The ability of the administrator to administer the pool in a cost efficient manner.

(b) The administrator shall serve for a period determined by the board of not less than three (3) years and not more than five (5) years and is subject to removal for cause. At least one (1) year prior to the expiration of the period of service by an administrator, the board shall invite all insurers, including the current administrator to submit bids to serve as the administrator for the succeeding period. Selection of the administrator for the succeeding period shall be made at least six (6) months prior to the end of the current period.

(c) The administrator shall:

(i) Perform all eligibility and administrative claims payment functions relating to the pool;

(ii) Establish a premium billing procedure for collection of premiums from insureds. Billings shall be made periodically as determined by the board;

(iii) Perform all necessary functions to assure timely payment of benefits to covered persons under the pool including but not limited to:

(A) Making available information relating to the proper manner of submitting a claim for benefits to the pool and distributing forms upon which submission is made;

(B) Evaluating the eligibility of each claim for payment by the pool.

(iv) Submit regular reports to the board regarding the pool operation. The board shall determine the frequency, content and form of the report;

(v) Determine net written and earned premiums, the expense of administration and the paid and incurred losses for the year and report the information to the board and the department on a form and in the manner prescribed by the commissioner;

(vi) Receive payment as provided in the plan of operation for its expenses incurred in the performance of its services.

26-43-105. Assessments; premium tax credit.

(a) After each calendar year, the administrator shall determine the pool net premiums which are premiums less administrative expense allowances, the pool administrative expenses and the pool incurred losses for the calendar year considering investment income and other appropriate gains and losses.

(b) Each insurer's assessment shall be determined by multiplying the total cost of pool operation by a fraction the numerator of which equals the insurer's premium and subscriber contract charges for health insurance written in the state during the preceding calendar year and the denominator of which equals the total of all premiums, subscriber contract charges written in the state and to the extent not preempted by federal law, one hundred ten percent (110%) of all claims paid by insurance arrangements in the state during the preceding calendar year. To the extent not preempted by federal law, each insurance arrangement's assessment shall be determined by multiplying the total cost of pool operation by a fraction the numerator of which equals one hundred ten percent (110%) of the benefits paid by the insurance arrangement on behalf of insureds in this state during the preceding calendar year and the denominator of which equals the total of all premiums, subscriber contract charges and one hundred ten percent (110%) of all benefits paid by insurance arrangements made on behalf of insureds in the state during the preceding calendar year. Health insurance premiums and benefits paid by an insurance arrangement that are less than an amount determined by the board to justify the cost of collection shall not be considered for purposes of determining assessments. To the extent not preempted by federal law, insurance arrangements shall report to the board on an annual basis on a form prescribed by the commissioner. Members shall file with the board annual reports and other reports deemed necessary by the board to determine each member's proportion of participation.

(c) On or before March 1 of each year, the board shall determine each member's proportion of participation in the pool for the calendar year based on annual statements and other reports deemed necessary by the board and filed by the member with the board. Any deficit incurred by the pool shall be

recouped by assessments apportioned under subsection (b) of this section by the board among members. Notification of assessments shall be mailed by the board not later than March 1 of each year. Assessments are due and payable within thirty (30) days after receipt of the assessment notice.

(d) For the total amount of assessments due from all members in any one (1) calendar year pursuant to this section up to four million dollars ($4,000,000.00), eighty percent (80%) of each member's proportionate contribution to the first two million dollars ($2,000,000.00) and fifty percent (50%) of the next two million dollars ($2,000,000.00) shall be allowed as a credit against any premium tax owed by the member under this code in the year for which the assessment is payable. The board shall not make a total assessment against all members of more than six million dollars ($6,000,000.00) in any one (1) fiscal year. Assessments received shall be used to defray the total cost of level one (1) pool operations first. Assessment amounts not required to support level one (1) pool operations will be used to support level two (2) operations before any general fund appropriation is used. The general fund appropriation shall only be used to support level two (2) operations. The board shall ensure that all expenses directly attributable to level one (1) individuals are paid from premiums, assessments and any withdrawals from previous reserves.

(e) The board may abate or defer, in whole or in part, the assessment of a member if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. In the event an assessment against a member 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 members in a manner consistent with the basis for assessments set forth in subsection (b) of this section. The member receiving an abatement or deferment shall remain liable to the pool for the deficiency for four (4) years.

(f) If assessments exceed actual losses and administrative expenses of the pool, the excess shall be paid to the state treasurer, credited to the account and used by the board to offset future losses or to reduce pool premiums. As used in this subsection, "future losses" includes reserves for incurred but unreported claims.

(g) The board may require initial and interim assessments as reasonable and necessary for the organizational,

administrative and interim operating expenses and to pay claims in excess of premiums collected. Any initial or interim assessments shall be credited as offsets against any regular assessments due following the close of the calendar year.

(h) Assessments collected pursuant to this act shall be paid to the state treasurer and credited to the account.

26-43-106. Minimum benefits; limitations.

(a) Pool coverage shall be offered to eligible persons subject to the termination and disenrollment provisions of W.S 26-43-103(e). The commissioner shall establish by rule and regulation the pool coverage, its schedule of benefits, exclusions and other limitations consistent with this act and taking into consideration the advice and recommendations of the board. The commissioner and the board annually shall review the pool coverage, its schedule of benefits, exclusions and limitations and make changes to reflect the levels of health insurance coverage provided in this state.

(b) In establishing the pool coverage, the commissioner shall:

(i) Consider the levels of health insurance provided in the state, medical economic factors deemed appropriate and the advice and recommendations of the board;

(ii) Promulgate benefit levels, deductibles, coinsurance factors, exclusions and limitations determined to be generally reflective of and commensurate with health insurance plans marketed in the state and required by this act. The commissioner shall offer at least two (2) plans that may include a higher deductible option or a health savings account option in order to provide less expensive coverage alternatives for pool participants;

(iii) Repealed by Laws 2005, ch. 57, § 2.

(iv) Repealed By Laws 2005, ch. 57, § 2.

(v) Design and employ cost containment measures and controls which may include but are not limited to, preadmission certification, concurrent inpatient review, case management, utilization reviews, exclusions or limitations concerning treatment and services, and member deductibles;

(vi) Offer for those individuals described in W.S. 26-43-103(d) a catastrophic health plan having a deductible level of twenty-five thousand dollars ($25,000.00), subject to the termination and disenrollment provisions of W.S. 26-43-103(e).

(c) Pool coverage shall not include medical costs associated with:

(i) Repealed by Laws 2019, ch. 16, § 2.

(ii) Cosmetic surgery;

(iii) Other procedures as determined by the board.

(d) Repealed by Laws 2019, ch. 16, § 2.

26-43-107. Premiums; standard risk rate.

(a) Separate schedules of premium rates based on plan coverage under the pool, age, sex and geographical location may apply for individual risks.

(b) The board shall determine the standard risk rate by calculating the average individual standard rate charged by the five (5) largest insurers offering coverages in the state comparable to each plan coverage under the pool. If five (5) insurers do not offer comparable coverage, the standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for the applicable coverage.

(c) Initial rates for pool coverage in the first year coverage is provided pursuant to this act shall not be less than one hundred fifty percent (150%) of rates established as applicable for individual standard risks. Subsequent rates may provide for the expected costs of claims including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other costs factors subject to the limitations provided by this subsection. Beginning July 1, 2007, except as provided in subsection (e) of this section, there shall be two (2) levels of eligibility. Level one (1) eligibility applies to persons with income equal to or greater than two hundred fifty percent (250%) of the federal poverty guideline. Level two (2) eligibility applies to persons with income below two hundred fifty percent (250%) of the federal poverty guideline. Premium rates for level one (1) eligibility shall be set at one hundred

fifty percent (150%) to two hundred five percent (205%) of rates applicable to individual standard risks. Premium rates for level two (2) eligibility shall be set at one hundred percent (100%) to one hundred forty percent (140%) of rates applicable to individual standard risks. All rates and rate schedules shall be submitted to the commissioner for approval. The rates shall be set as close as practical to the lower end of the range provided.

(d) Premiums collected pursuant to this section shall be paid to the state treasurer and credited to the account.

(e) Repealed by Laws 2019, ch. 16, § 2.

26-43-108. Preexisting conditions.

(a) Pool coverage shall not exclude charges or expenses incurred for longer than the first twelve (12) months following the effective date of coverage as to any condition for which during the six (6) month period immediately preceding the effective date of coverage medical advice, care or treatment was recommended or received. The preexisting coverage limitation set forth in this section shall not apply to a federally defined eligible individual.

(b) Preexisting condition exclusions shall be waived to the extent to which similar exclusions, if any, have been satisfied under any prior health insurance coverage which was terminated and coverage in the pool is effective from the date on which the prior coverage was terminated if application for pool coverage is made not later than ninety (90) days following the termination.

26-43-109. Benefit payments reduction.

(a) Benefits otherwise payable under pool coverage are reduced by:

(i) All amounts paid or payable through any other health insurance or insurance arrangement;

(ii) All hospital and medical expense benefits paid or payable under any workers' compensation coverage or automobile medical payment or liability insurance whether provided on the basis of fault or nonfault; and

(iii) Any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program except Medicaid.

(b) The administrator or the board has a cause of action against an eligible person for the recovery of the amount of benefits paid which are not for covered expenses. Benefits due from the pool may be reduced or refused as a setoff against any amount recoverable under this section.

26-43-110. Immunity.

The participation in the pool as members, the establishment of rates, forms or procedures or any other joint or collective action required by this act shall not be the basis of any legal action, criminal or civil liability or penalty against the board, the pool or pool members.

26-43-111. Tax exemption.

The pool established pursuant to this act is exempt from insurance premium taxes.

26-43-112. Account created; payments; investment.

There is created an account within the trust and agency fund in which all money received, earned or collected pursuant to this act shall be credited and continuously appropriated for the purposes of this act. All claims, costs of administration and other necessary expenses incurred pursuant to this act shall be paid from the account. All money in the account not immediately necessary for the purposes of this act, which amount is certified by the board to the state treasurer, shall be invested and any interest earned shall be credited to the account.

26-43-113. Termination of provisions.

This act is not effective after June 30, 2030.

26-43-114. Enrollment capacity planning.

The board shall annually estimate the funds available to the plan through premiums, assessments and legislative appropriations for the subsequent fiscal year and shall determine the maximum number of individuals who may be enrolled for that year without incurring total costs of operation in excess of estimated available funds. The board shall take steps

necessary to assure that plan enrollment does not exceed the maximum enrollment capacity determined for that year. In determining enrollment capacity for purposes of this section, the board shall provide for the enrollment in the pool of all federally eligible individuals.

ARTICLE 2 - HEALTH CARE REFORM DEMONSTRATION PROJECT

26-43-201. Repealed by Laws 2010, ch. 96, § 1.

26-43-202. Repealed by Laws 2010, ch. 96, § 1.

26-43-203. Repealed by Laws 2010, ch. 96, § 1.

26-43-204. Repealed by Laws 2010, ch. 96, § 1.

26-43-205. Repealed by Laws 2010, ch. 96, § 1.

26-43-206. Repealed by Laws 2010, ch. 96, § 1.

26-43-207. Repealed by Laws 2021, ch. 149, § 3.

ARTICLE 3 - AIR AMBULANCE MEMBERSHIP ORGANIZATIONS

26-43-301. Definitions; applicability.

(a) As used in this article, "air ambulance membership organization" means an entity that, in exchange for fees, dues, charges or other consideration, provides:

(i) Discounts to members for the cost of services the organization provides as an air ambulance service company; or

(ii) Access for members to providers of air ambulance services and the right to receive air ambulance services from those providers. For purposes of this paragraph, "air ambulance membership organization" means the entity that contracts with health care providers, individuals, employees, groups, provider networks or other air ambulance membership organizations to offer access to air ambulance services and that determines the fees, dues, or charges to air ambulance membership organization members.

(b) The registration requirements of this article shall not apply to:

(i) An air ambulance membership organization that is otherwise subject to the provisions of this title and is required to be licensed under this title;

(ii) A health care provider who provides discounts to patients without any cost or fee of any kind to the patient.

26-43-302. Air ambulance membership organizations; certificate of registration; application.

(a) An air ambulance membership organization shall obtain a certificate of registration from the commissioner before operating as an air ambulance membership organization in Wyoming.

(b) An air ambulance membership organization seeking a certificate of registration from the commissioner shall apply on a form created and prescribed by the commissioner. The application shall include:

(i) An application fee not to exceed five hundred dollars ($500.00);

(ii) Information regarding whether a previous application for a certificate of registration under this article or for a substantially similar certificate under the laws of another state has been denied, revoked, suspended or terminated;

(iii) Information regarding whether the applicant is currently under investigation or the subject of any pending action and whether the applicant has been found in violation of any statute or regulation in any jurisdiction in the last five (5) years;

(iv) Information sufficient for the commissioner to determine whether the applicant has adequate expertise and experience to operate an air ambulance membership organization and is of good character;

(v) Certification that the applicant has established a dedicated toll-free telephone number for its customers and an internet website that makes available the names and addresses of all current air ambulance providers with which the applicant has contracted directly or through a provider network;

(vi) Proof that the applicant has posted a surety bond and has established a reserve fund as required by W.S. 26-43-305(f).

(c) Upon receipt of an application, the commissioner shall review the application and shall notify the applicant of any deficiencies in the application not later than twenty-one (21) days after receiving the application. Not more than ninety (90) days after receipt of an application containing all required information, the commissioner shall issue a certificate of registration to an applicant that has satisfied all requirements imposed by this article.

(d) A certificate of registration issued under this section shall be effective for one (1) year after the date of issuance unless renewed as provided by W.S. 26-43-303(a).

26-43-303. Certificate of registration; renewal; suspension; revocation.

(a) Not less than ninety (90) days before a certificate of registration expires, an air ambulance membership organization seeking to maintain its registration shall submit a renewal application on a form prescribed by the commissioner, the annual report required under W.S. 26-43-307(a) and a renewal fee not to exceed three hundred dollars ($300.00). The commissioner shall renew the certificate of registration for any air ambulance membership organization that is in compliance with the provisions of this article and any rules promulgated pursuant to this article. An air ambulance membership organization may renew its registration for up to one (1) year after expiration of its certificate of registration by paying the renewal fee and a late fee equal to the renewal fee. An air ambulance membership organization shall not enroll new members until their registration is renewed in accordance with this section or a new certificate of registration is approved.

(b) The commissioner may suspend or revoke a certificate of registration after notice and an opportunity for a hearing held in accordance with this article and the Wyoming Administrative Procedure Act if the commissioner has reasonable cause to believe that the air ambulance membership organization:

(i) Is not operating in compliance with the provisions of this article;

(ii) Has advertised, merchandized or attempted to merchandise its services in a manner that misrepresents its services or capacity for service;

(iii) Has engaged in deceptive, misleading or unfair practices prohibited by the Wyoming Consumer Protection Act;

(iv) Is not fulfilling its obligations as an air ambulance membership organization; or

(v) Would be hazardous to the members of the air ambulance membership organization if continued operation were permitted.

(c) If the commissioner has reasonable cause under subsection (b) of this section, the commissioner shall notify the air ambulance membership organization in writing specifically stating the grounds for suspending or revoking a certificate of registration. The certificate holder may demand a hearing not later than thirty (30) days after receipt of the notice. Any hearing held under this subsection shall be conducted pursuant to the Wyoming Administrative Procedure Act.

(d) Upon reasonable cause shown, the commissioner may suspend the authority of the air ambulance membership organization to enroll new members for a specified period of time not to exceed ninety (90) days. Any suspension under this subsection shall specify in writing any conditions the air ambulance membership organization shall meet before reinstatement of its authority to enroll new members.

(e) The commissioner may rescind or modify any suspension ordered under this section. Any modification that results in a suspension being extended or additional conditions imposed on an air ambulance membership organization shall not take effect until after notice is given to the air ambulance membership organization with an opportunity for a hearing held in accordance with this article and the Wyoming Administrative Procedure Act.

(f) No certificate of registration of an air ambulance membership organization that has been suspended or revoked shall be reinstated unless requested by the air ambulance membership organization. The commissioner shall not grant the request for reinstatement if the commissioner finds by a preponderance of the evidence that the circumstances for which the suspension or revocation occurred still exist or are likely to recur.

(g) In lieu of a suspension or revocation of a certificate of registration, the commissioner may:

(i) Issue and serve upon an air ambulance membership organization a violation notice that includes the basis for the violation and an order requiring the air ambulance membership organization to cease and desist from engaging in the acts or practices that caused the issuance of the violation notice;

(ii) Impose a civil penalty of not more than one thousand dollars ($1,000.00) for each violation.

(h) An air ambulance membership organization shall immediately notify the commissioner if a certificate of registration or other substantially similar authorization issued in another jurisdiction has been suspended, revoked or not renewed.

26-43-304. Air ambulance membership organizations; powers and duties of the commissioner; rulemaking; costs.

(a) The commissioner is authorized to:

(i) Examine or investigate the affairs of an air ambulance membership organization to ensure compliance with the provisions of this article;

(ii) Order any air ambulance membership organization or applicant to produce materials pertaining to air ambulance membership affairs, including any records, books, files, advertising and solicitation materials and any other information necessary to ensure compliance with this article;

(iii) Take statements under oath to determine whether the air ambulance membership organization or an applicant is in violation of the provisions of this article.

(b) An air ambulance membership organization found to have violated any provision of this article after an examination or investigation under this section shall pay all costs and fees associated with the examination or investigation.

(c) The commissioner shall promulgate any rules necessary to carry out the provisions of this article.

26-43-305. Charges authorized; written agreements required; cancellation of memberships; duties.

(a) An air ambulance membership organization may assess a periodic charge and a reasonable one-time application processing fee to its members.

(b) All terms and conditions for memberships of an air ambulance membership organization shall be provided in writing to each member. An air ambulance membership organization meeting the definition specified in W.S. 26-43-301(a)(ii) shall have an agreement in writing with each air ambulance provider offering air ambulance services to its members. The written provider agreement may be entered into directly with the provider or with an entity that hires or represents the provider.

(c) A member of an air ambulance membership organization's plan shall have the right to cancel his membership in the plan at any time. If the member cancels his membership not later than thirty (30) days after purchasing a plan, the air ambulance membership organization shall refund to the member any one-time charges that exceed thirty dollars ($30.00) and all periodic charges. For purposes of this subsection, cancellation occurs when notice of cancellation is mailed or otherwise delivered to the air ambulance membership organization.

(d) If an air ambulance membership organization cancels a membership for any reason other than nonpayment of charges by a member, the air ambulance membership organization shall issue a pro rata refund of all periodic charges to the member.

(e) An air ambulance membership organization or an agent, broker or marketer who sells memberships for an air ambulance membership organization shall disclose all charges for each air ambulance membership organization membership to all prospective members.

(f) An air ambulance membership organization shall:

(i) Post a surety bond with one (1) or more surety companies approved by the commissioner in the amount of five thousand dollars ($5,000.00) for every one thousand (1,000) members of the organization who are residents of the state of Wyoming or portion thereof;

(ii) Establish a reserve fund at any financial institution approved by the commissioner in the amount of three

dollars ($3.00) for each member currently part of a plan that the air ambulance membership organization offers. The reserve fund shall be for the benefit of the members and to guarantee that any plan the air ambulance membership organization offers continues until all memberships or plans are terminated. No amount shall be required to be deposited for any family members of the plan member's household unless the family members are separately participating or subscribed to the organization's plan. No further deposits shall be required under this paragraph after the total amount of the reserve fund and surety bond required under paragraph (i) of this subsection exceeds two hundred thousand dollars ($200,000.00).

(g) An air ambulance membership organization shall pay any costs of collection upon a judgment in favor of a plan member and attorney fees in any successful action brought by a plan member.

26-43-306. Violations; unfair trade practices; penalties.

In addition to any penalties and other enforcement of this article, any person who willfully violates any provision of this article may be subject to a civil penalty not to exceed one thousand dollars ($1,000.00) for each willful violation.

26-43-307. Reporting requirements; notice to commissioner; penalties.

(a) Not less than ninety (90) days before expiration of a certificate of registration, an air ambulance membership organization seeking renewal of its certificate of registration shall submit an annual report to the commissioner in a form prescribed by the commissioner. The report shall include:

(i) An updated list of the names and addresses of all air ambulance providers or air ambulance service providers responsible for the conduct of the air ambulance membership organization's affairs along with disclosure of the extent and nature of any contracts or arrangements with those persons, including any possible conflicts of interest;

(ii) The number of members in Wyoming who are enrolled in any membership offered by the air ambulance membership organization;

(iii) A list of any membership agreements currently active or entered into with a governmental entity in Wyoming

that provides membership of the air ambulance membership organization to all residents of that governmental entity. As used in this paragraph, "governmental entity" means the governing body of a county or municipality in Wyoming;

(iv) Any other information related to the air ambulance membership organization as required by the commissioner to ensure compliance with the provisions of this article.

(b) An air ambulance membership organization seeking renewal that fails to file an annual report in the form or before the deadline specified in subsection (a) of this section shall be ineligible for renewal until any deficiency is remedied.

(c) Upon notice by the commissioner, an air ambulance membership organization failing to comply with subsection (a) of this section shall lose its authority to enroll new members or to do business in Wyoming if the violation continues beyond a time specified by the commissioner.

(d) An air ambulance membership organization shall provide the commissioner notice of any change in the organization's name, address, telephone number, address for the principal place of business, mailing address or internet website address not less than thirty (30) days before making the change.

26-43-308. Advertisements; marketing; required disclosures.

(a) All advertisements, marketing materials, brochures, air ambulance membership cards, presentations and any other communications of an air ambulance membership organization shall be truthful and not misleading in fact or in implication.

(b) An air ambulance membership organization advertising or marketing its memberships to Wyoming residents shall:

(i) Submit all written advertisements and marketing materials to the commissioner for review for compliance with this article;

(ii) Not use language in its advertisements or marketing that could reasonably mislead a person into believing that the air ambulance membership plan is insurance;

(iii) Not use language in its advertisements, marketing materials, brochures or presentations with respect to being licensed or registered by a state insurance department or with respect to being provided by a governmental entity in a manner that could reasonably mislead an individual into believing that the air ambulance membership plan is insurance or has been endorsed by the state or any Wyoming governmental entity;

(iv) Not have restrictions on access to air ambulance membership organizations, including waiting periods and notification periods.

(c) An air ambulance membership organization shall make the following general disclosures in writing in bold and not less than twelve (12) point font on the first content page of any advertisement, marketing material or brochure made available to prospective members or the public:

(i) The plan is a membership plan and is not insurance coverage;

(ii) For air ambulance membership organizations as defined by W.S. 26-43-301(a)(ii), that the range of discounts for air ambulance services provided under the membership will vary depending on the provider and the services offered;

(iii) The toll-free number and internet website address for the air ambulance membership organization where prospective members can obtain additional information about the services offered by the air ambulance membership organization.

(d) An air ambulance membership organization shall provide the disclosures required by subsection (c) of this section orally to any person who makes initial contact with an air ambulance membership organization by telephone.

(e) Before a person purchases a membership from an air ambulance membership organization, the air ambulance membership organization shall mail, give or, with the consent of the person, email to the person a separate document printed in bold and not less than twelve (12) point font that contains the following disclosures:

(i) That the air ambulance membership is not insurance coverage;

(ii) That, if eligible and covered under Medicare, the prospective member may consult with a representative of the Medicare program to determine the extent of applicable Medicare coverage and what the member's payment obligations will be if transported by air ambulance;

(iii) That the prospective member may be covered by an air ambulance membership organization under a membership provided by a governmental entity;

(iv) A detailed list of all one-time and periodic fees that are and will be charged to the prospective member to join the air ambulance membership organization;

(v) The Wyoming counties served by the air ambulance membership organization;

(vi) That, in an emergency and if the prospective member is outside of the air ambulance membership organization's service area, air ambulance services may be provided by another air ambulance provider or air ambulance membership organization, and the benefits of the air ambulance membership organization that the prospective member is joining may not apply to the services provided by another air ambulance provider, and in such case the prospective member may be responsible for the entire bill;

(vii) That if the member cancels the membership not later than thirty (30) days after purchasing a plan, the air ambulance membership organization will refund to the member any one-time charges paid by the member that exceed thirty dollars ($30.00) and all periodic charges paid by the member;

(viii) That the air ambulance membership organization may not be the company called in the event of an emergency and that the member may be responsible for the entire bill if a different air ambulance service company provides the service.

CHAPTER 44 - INSURANCE HOLDING COMPANY SYSTEM REGULATORY ACT

26-44-101. Definitions.

(a) As used in this act:

(i) "Affiliate" or "affiliated" means a person that directly, or indirectly through one (1) or more intermediaries,

controls, or is controlled by, or is under common control with a specified person;

(ii) "Commissioner" means the insurance commissioner as defined by W.S. 26-1-102(a)(viii);

(iii) "Control" means the power, direct or indirect, 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 or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted as provided by W.S. 26-44-104 that control does not exist in fact. The commissioner may determine, after furnishing all interested persons notice and opportunity to be heard and making specific findings of fact to support the determination, that control exists in fact, notwithstanding the absence of a presumption to that effect;

(iv) "Insurance holding company system" means two (2) or more affiliated persons, one (1) or more of which is an insurer;

(v) "Insurance subsidiary" means any subsidiary which transacts insurance as defined in W.S. 26-1-102(a)(xxx);

(vi) "Insurer" means as set forth in W.S. 26-1-102(a)(xvi), (xix) and (xxviii) 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; or

(B) Fraternal benefit societies.

(vii) "Person" means as defined in W.S. 26-1-102(a)(xx);

(viii) "Security holder" means a person who owns any security of a specified person, including common stock, preferred stock, debt obligations and any other security

convertible into or evidencing the right to acquire any of the foregoing;

(ix) "Subsidiary" means an affiliate controlled by a specified person directly or indirectly through one (1) or more intermediaries;

(x) "Voting security" means any security convertible into or evidencing a right to acquire a voting security;

(xi) "Enterprise risk" means any activity, circumstance, event or series of events involving one (1) or more affiliates of an insurer that, if not remedied promptly, is likely to have a material adverse effect upon the financial condition or liquidity of the insurer or its insurance holding company system as a whole, including, but not limited to, anything that would cause the insurer's risk-based capital to fall into company action level as set forth in W.S. 26-48-103 and 26-48-203 or would cause the insurer to be in hazardous financial condition pursuant to W.S. 26-3-116;

(xii) "Group wide supervisor" means the regulatory official authorized to conduct and coordinate group wide supervision activities who is determined or acknowledged by the commissioner to have sufficient significant contacts with the internationally active insurance group under W.S. 26-44-119;

(xiii) "Internationally active insurance group" means an insurance holding company system that:

(A) Includes an insurer registered under W.S. 26-44-104; and

(B) Meets all of the following criteria:

(I) Writes premiums in at least three (3) countries;

(II) The percentage of its gross premiums written outside of the United States is at least ten percent (10%) of its total gross written premiums;

(III) Based on a three (3) year rolling average, its total assets are at least fifty billion dollars ($50,000,000,000.00) or its total gross written premiums are at least ten billion dollars ($10,000,000,000.00).

(xiv) "Group capital calculation instructions" means the group capital calculation instructions as adopted by the NAIC and as amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC;

(xv) "NAIC liquidity stress test framework" means a separate NAIC publication which includes a history of the NAIC's development of regulatory liquidity stress testing, the scope criteria applicable for a specific data year, and the liquidity stress test instructions and reporting templates for a specific data year, such scope criteria, instructions and reporting template being as adopted by the NAIC and as amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC;

(xvi) "Scope criteria," as detailed in the NAIC liquidity stress test framework, means the designated exposure bases along with minimum magnitudes thereof for the specified data year, used to establish a preliminary list of insurers considered scoped into the NAIC liquidity stress test framework for that data year;

(xvii) "Third-party consultant designated by the commissioner" means any independent or consulting actuarial, rating or other technical service provider with whom the commissioner contracts pursuant to W.S. 26-2-106(d);

(xviii) "This act" means W.S. 26-44-101 through 26-44-120.

26-44-102. Subsidiaries of insurers.

(a) Any domestic insurer, either by itself or in cooperation with one (1) or more persons, may organize or acquire one (1) or more subsidiaries provided the stock of the insurer's subsidiaries are valued in accordance with the provisions of W.S. 26-6-302. Subsidiaries may conduct any kind of business or businesses and their authority to do so shall not be limited by reason of the fact that they are subsidiaries of a domestic insurer.

(b) In addition to investments in common stock, debt obligations and other securities permitted under all other sections of this chapter, a domestic insurer may also:

(i) Invest in common stock, preferred stock, debt obligations and other securities of one (1) or more

subsidiaries, amounts which do not exceed the lesser of ten percent (10%) of the insurer's assets or fifty percent (50%) of the insurer's surplus as regards policyholders, provided that after the investments, the insurer's surplus as regards policyholders will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs. In calculating the amount of the investments, investments in domestic or foreign insurance subsidiaries and health maintenance organizations shall be excluded, and there shall be included:

(A) Total net monies 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 the subsidiary whether or not represented by the purchase of capital stock or issuance of other securities; and

(B) 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.

(ii) Invest any amount in common stock, preferred stock, debt obligations and other securities of one (1) or more subsidiaries engaged or organized to engage exclusively in the ownership and management of assets authorized as investments for the insurer, 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 insurer to exceed any of the investment limitations specified in paragraph (i) of this subsection or in W.S. 26-7-102 through 26-7-116 applicable to the insurer. For the purposes of this paragraph, "the total investment of the insurer" shall include:

(A) Any direct investment by the insurer in an asset; and

(B) The insurer's proportionate share of any investment in an asset by any subsidiary of the insurer, which shall be calculated by multiplying the amount of the subsidiary's investment by the percentage of the ownership of the subsidiary.

(iii) With the approval of the commissioner, invest any greater amount in common stock, preferred stock, debt obligations or other securities of one (1) or more subsidiaries,

provided that after the investment the insurer's surplus as regards policyholders will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

(c) Whether any investment pursuant to subsection (b) of this section meets the applicable requirements is to be determined before the investment is made by calculating the applicable investment limitations as though the investment had already been 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 day they were made, net of any return of capital invested, not including dividends.

(d) If an insurer ceases to control a subsidiary, it shall dispose of any investment in the subsidiary made pursuant to this section within three (3) years from the time of the cessation of control or within any further time the commissioner may prescribe, unless the investment meets the requirements for investment under any other section of this title and the insurer so notifies the commissioner.

26-44-103. Acquisition of control of or merger with domestic insurer.

(a) No person other than the issuer shall make a tender offer for or a request or invitation for tenders of, or agreement to exchange securities for or otherwise acquire, any voting security or any security convertible into a voting security of a domestic insurer or of any other person controlling a domestic insurer if, after consummation, the person would, directly or indirectly, be in control of the insurer and no person shall enter into an agreement to merge with or otherwise acquire control of a domestic insurer unless:

(i) Thirty (30) days prior to the above transactions the person has filed with the commissioner and has sent to the insurer a statement containing the information required by this section;

(ii) The offer, request, invitation, agreement or acquisition has been approved by the commissioner. For purposes of this section a domestic insurer includes any person controlling a domestic insurer unless the person, as determined by the commissioner, is either directly or through its affiliates primarily engaged in business other than the business

of insurance. For the purposes of this section, "person" does not include any securities broker holding, in the usual and customary broker's function, less than twenty percent (20%) of the voting securities of an insurance company or of any person which controls an insurance company; and

(iii) If any controlling person of a domestic insurer is seeking to divest its controlling interest in the domestic insurer in any manner, the controlling person has filed with the commissioner, with a copy to the insurer, confidential notice of its proposed divestiture at least thirty (30) days prior to the cessation of control. The commissioner shall determine those instances in which the party seeking to divest or to acquire a controlling interest in an insurer will be required to file for and obtain approval of the transaction. The information shall remain confidential until the conclusion of the transaction unless the commissioner, in his discretion determines that confidential treatment will interfere with enforcement of this section. If the statement referred to in paragraph (i) of this subsection is otherwise filed by the acquiring person or as otherwise required, this paragraph shall not apply.

(b) The preacquisition statement required by subsection (a) of this section shall be made under oath or affirmation and shall contain the following:

(i) The name and address of each person by whom or on whose behalf the merger or other acquisition of control referred to in subsection (a) of this section is to be made and the following:

(A) If the person is an individual, his principal occupation and all offices and positions held during the past five (5) years, and any conviction of crimes other than minor traffic violations during the past ten (10) years;

(B) If the person is not an individual, a report of the nature of its business operations during the past five (5) years or for such lesser period as the person and any predecessors of the person 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 shall include for each individual the information required by subparagraph (A) of this paragraph.

(ii) 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 where funds were or are to be obtained for that purpose including any pledge of the insurer's stock or the stock of any of its subsidiaries or controlling affiliates, and the identity of persons furnishing the funds where a source of the funds is a loan made in the lender's ordinary course of business, the identity of the lender shall remain confidential if the person filing the statement so requests;

(iii) Fully audited financial information as to the earnings and financial condition of each acquiring party for the preceding five (5) fiscal years or for any lesser period the acquiring party and any of its predecessors have been in existence, and similar unaudited information as of a date not earlier than ninety (90) days before the filing of the statement;

(iv) Any plans or proposals which each acquiring party may have to liquidate the insurer, 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;

(v) The number of shares of any security referred to in subsection (a) of this section which each acquiring party proposes to acquire, and the terms of the offer, request, invitation, agreement or acquisition referred to in subsection (a) of this section, and a statement as to the method by which the fairness of the proposal was determined;

(vi) The amount of each class of any security referred to in subsection (a) which is beneficially owned or concerning which there is a right to acquire beneficial ownership by each acquiring party;

(vii) A full description of any contracts, arrangements or understandings with respect to any security referred to in subsection (a) of this section 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 shall identify the persons with whom the contracts, arrangements or understandings have been entered;

(viii) A description of the purchase of any security referred to in subsection (a) of this section during the twelve (12) 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;

(ix) A description of any recommendations to purchase any security referred to in subsection (a) of this section made during the twelve (12) 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;

(x) 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 (a) of this section, and of additional related soliciting material;

(xi) The term of any agreement, contract or understanding made with or proposed to be made with any broker-dealer as to solicitation of securities referred to in subsection (a) of this section for tender, and the amount of any fees, commissions or other compensation to be paid to broker-dealers;

(xii) An agreement by the person required to file the statement referred to in subsection (a) of this section that it will provide the annual report, specified in W.S. 26-44-104(n), for so long as control exists;

(xiii) An acknowledgement by the person required to file the statement referred to in subsection (a) of this section that the person and all subsidiaries within its control in the insurance holding company system will provide information to the commissioner upon request as necessary to evaluate enterprise risk to the insurer; and

(xiv) Any additional information as the commissioner may by rule or regulation prescribe as necessary or appropriate for the protection of policyholders of the insurer or in the public interest.

(c) If the person required to file the statement referred to in subsection (a) of this section is a partnership, limited

partnership, syndicate or other group, the commissioner may require that the information called for by subsection (b) of this section shall 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 (a) of this section is a corporation, the commissioner may require that the information called for by subsection (b) of this section shall 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 (10%) of the outstanding voting securities of the corporation.

(d) If any material change occurs in the facts set forth in the statement filed with the commissioner and sent to the insurer pursuant to this section, an amendment setting forth the change, together with copies of all documents and other material relevant to the change, shall be filed with the commissioner and sent to the insurer within two (2) business days after the person learns of the change.

(e) If any offer, request, invitation, agreement or acquisition referred to in subsection (a) of this section 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 (a) of this section may utilize documents prepared for those laws in furnishing the information called for by this section.

(f) The commissioner shall approve any merger or other acquisition of control referred to in subsection (a) of this section unless after a public hearing he finds that:

(i) After the change of control, the domestic insurer referred to in subsection (a) of this section would not be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which it is presently licensed;

(ii) The effect of the merger or other acquisition of control would substantially lessen competition in insurance in Wyoming or tend to create a monopoly in Wyoming. The commissioner may condition the approval of the merger or other

acquisition on the removal of the basis of disapproval within a specified period of time;

(iii) The financial condition of any acquiring party might jeopardize the financial stability of the insurer, or prejudice the interest of its policyholders;

(iv) The plans or proposals which the acquiring party has to liquidate the insurer, 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 insurer and not in the public interest;

(v) The competence, experience and integrity of those persons who would control the operation of the insurer are such that it would not be in the interest of policyholders of the insurer and of the public to permit the merger or other acquisition of control; or

(vi) The acquisition is likely to be hazardous or prejudicial to the insurance buying public.

(g) The public hearing referred to in subsection (f) of this section shall be held within thirty (30) days after the statement required by subsection (a) of this section is filed, and at least twenty (20) days notice of the hearing shall be given by the commissioner to the person filing the statement. Not less than seven (7) days notice of the public hearing shall be given by the person filing the statement to the insurer and to any other persons designated by the commissioner. The commissioner shall make a determination within thirty (30) days after the conclusion of the hearing. At the hearing, the person filing the statement, the insurer, any person to whom notice of hearing was sent, and any other person whose interest may be affected shall have the right to present evidence, examine and cross-examine witnesses, and offer oral and written arguments and shall be entitled to conduct discovery proceedings in the same manner as is presently allowed in district court. All discovery proceedings shall be concluded not later than three (3) days prior to the commencement of the public hearing.

(h) If the proposed acquisition of control will require the approval of more than one (1) commissioner, the public hearing referred to in subsection (g) of this section may be held on a consolidated basis upon request of the person filing the statement referred to in subsection (a) of this section.

The person shall file the statement referred to in subsection (a) of this section with the National Association of Insurance Commissioners within five (5) days of making the request for a public hearing. A commissioner may opt out of a consolidated hearing, and shall provide notice to the applicant of the opt-out within ten (10) days of the receipt of the statement referred to in subsection (a) of this section. A hearing conducted on a consolidated basis shall be public and shall be held within the United States before the commissioners of the states in which the insurers are domiciled. The commissioners shall hear and receive evidence. A commissioner may attend the hearing in person or by telecommunication.

(j) In connection with a change of control of a domestic insurer, any determination by the commissioner that the person acquiring control of the insurer shall be required to maintain or restore the capital of the insurer to the level required by the laws and regulations of this state shall be made not later than sixty (60) days after the date of notification of the change in control submitted pursuant to subsection (a) of this section.

(k) The commissioner may retain at the acquiring person's expense any attorneys, actuaries, accountants and other experts not otherwise a part of the commissioner's staff reasonably necessary to assist the commissioner in reviewing the proposed acquisition of control.

(m) The provisions of this section do not apply to:

(i) Any transaction which is subject to the provisions of W.S. 26-24-146 through 26-24-149;

(ii) Any offer, request, invitation, agreement or acquisition which the commissioner by order shall exempt as not having been made or entered into for the purpose and not having the effect of changing or influencing the control of a domestic insurer.

(n) The following shall be violations of this section:

(i) The failure to file any statement, amendment or other material required to be filed pursuant to subsection (a) or (b) of this section; or

(ii) The effectuation or any attempt to effectuate an acquisition of control of, divestiture of, or merger with, a domestic insurer unless the commissioner has given approval.

(o) The Wyoming courts have jurisdiction over every person who files a statement with the commissioner under this section, and overall actions arising out of violations of this section. Any person filing a statement with the commissioner appoints the commissioner as his agent for service of process for actions arising under this section. The commissioner shall send copies of all legal services by certified mail to the appropriate person at his last known address.

26-44-104. Registration of insurers; group capital calculations; liquidity stress test results.

(a) Every insurer which is authorized to do business in this state and which is a member of an insurance holding company system shall register with the commissioner, except a foreign insurer subject to registration requirements and standards adopted by statute or regulation in the jurisdiction of its domicile which are substantially similar to those contained in this section, W.S. 26-44-105(a), 26-44-106 and 26-44-108 and a provision which substantially requires each registered insurer to keep current the information required to be disclosed in its registration statement by reporting all material changes or additions within fifteen (15) days after the end of the month in which it learns of each such change or addition.

(b) Any insurer which is subject to registration under this section shall register within fifteen (15) days after it becomes subject to registration, and annually thereafter by July 1 of each year for the previous calendar year, unless the commissioner for good cause shown extends the time for registration, and then within the extended time. The commissioner may require any insurer authorized to do business in the state which is a member of an insurance holding company system, and which is not subject to registration under this section, to furnish a copy of the registration statement, the summary specified in W.S. 26-44-104(d) or other information filed by the insurance company with the insurance regulatory authority of the domiciliary jurisdiction.

(c) Every insurer subject to registration shall file the registration statement containing any information required by regulation by the commissioner and in the form prescribed by

regulation by the commissioner, which shall contain the following current information:

(i) The capital structure, general financial condition, ownership and management of the insurer and any person controlling the insurer;

(ii) The identity and relationship of every member of the insurance holding company system;

(iii) The following agreements in force, and transactions currently outstanding or which have occurred during the last calendar year between the insurer and its affiliates:

(A) Loans, other investments, or purchases, sales or exchanges of securities of the affiliates by the insurer or of the insurer by its affiliates;

(B) Purchases, sales or exchange of assets;

(C) Transactions not in the ordinary course of business;

(D) Guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the insurer's assets to liability, other than insurance contracts entered into in the ordinary course of the insurer's business;

(E) All management agreements, service contracts and all cost-sharing arrangements;

(F) Reinsurance agreements;

(G) Dividends and other distributions to shareholders; and

(H) Consolidated tax allocation agreements.

(iv) Any pledge of the insurer's stock, including stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system;

(v) If requested by the commissioner, the insurer shall include financial statements of or within an insurance holding company system, including all affiliates. Financial statements may include but are not limited to annual audited

financial statements filed with the United States Securities and Exchange Commission pursuant to the Securities Act of 1933, as amended, or the Securities Exchange Act of 1934, as amended. An insurer required to file financial statements pursuant to this paragraph may satisfy the request by providing the commissioner with the most recently filed parent corporation financial statements that have been filed with the SEC;

(vi) Other matters concerning transactions between registered insurers and any affiliates as may be included from time to time in any registration forms adopted or approved by the commissioner;

(vii) Statements that the insurer's board of directors oversees corporate governance and internal controls and that the insurer's officers or senior management have approved, implemented, and continue to maintain and monitor corporate governance and internal control procedures;

(viii) Any other information required by the commissioner by rule or regulation.

(d) All registration statements shall contain a summary outlining all items in the current registration statement representing changes from the prior registration statement.

(e) Information need not be disclosed on the registration statement filed pursuant to subsection (b) of this section if the information is not material for the purposes of this section. Unless the commissioner by rule, regulation or order provides otherwise, sales, purchases, exchanges, loans or extensions of credit, investments or guarantees involving one-half of one percent (.5%) or less of an insurer's admitted assets as of December 31, of the year immediately preceding are not material for purposes of this section. As used in this subsection, "material" shall not apply for purposes of the group capital calculation or the NAIC liquidity stress test framework.

(f) Each registered insurer shall report to the commissioner all dividends and other distributions to shareholders within fifteen (15) business days following the declaration of the dividend or distribution.

(g) Any person within an insurance holding company system subject to registration is required to provide complete and accurate information to an insurer where the information is

reasonably necessary to enable the insurer to comply with the provisions of this act.

(h) The commissioner shall terminate the registration of any insurer which demonstrates that it no longer is a member of an insurance holding company system.

(j) The commissioner may require or allow two (2) or more affiliated insurers subject to registration under this act to file a consolidated registration statement.

(k) The commissioner may allow an insurer 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 insurer which is required to register under subsection (a) of this section and to file all information and material required to be filed under this section.

(m) Any person may file with the commissioner a disclaimer of affiliation with any authorized insurer or the disclaimer may be filed by the insurer or any member of an insurance holding company system. The disclaimer shall fully disclose all material relationships and bases for affiliation between the person and the insurer as well as the basis for disclaiming the affiliation. A disclaimer of affiliation shall be deemed to have been approved unless the commissioner, within thirty (30) days following receipt of a complete disclaimer, notifies the filing party the disclaimer is disallowed. In the event of disallowance, the disclaiming party may request an administrative hearing, which shall be granted. The disclaiming party shall be relieved of its duty to register under this section if approval of the disclaimer has been granted by the commissioner, or if the disclaimer is deemed to have been approved.

(n) Beginning July 1, 2014, the ultimate controlling person of every insurer subject to registration shall also file an annual enterprise risk report. The report shall, to the best of the ultimate controlling person's knowledge and belief, identify the material risks within the insurance holding company system that could pose enterprise risk to the insurer. The report shall be filed with the lead state commissioner of the insurance holding company system as determined by the procedures within the Financial Analysis Handbook adopted by the National Association of Insurance Commissioners.

(o) The failure to file a registration statement or any summary of the registration statement or enterprise risk filing required by this section within the time specified for filing shall be a violation of this section.

(p) Except as otherwise provided in this subsection, the ultimate controlling person of every insurer subject to registration under this section shall concurrently file with the registration an annual group capital calculation, including the group capital ratio produced within the calculation, as directed by the lead state commissioner. The report shall be completed in accordance with the NAIC group capital calculation instructions, which may permit the lead state commissioner to allow a controlling person that is not the ultimate controlling person to file the group capital calculation. The report shall be filed with the lead state commissioner of the insurance holding company system as determined by the commissioner in accordance with the procedures within the financial analysis handbook adopted by the NAIC. The following shall apply to this subsection:

(i) The following insurance holding company systems are exempt from filing the group capital calculation:

(A) An insurance holding company system that has only one (1) insurer within its holding company structure, that only writes business and is only licensed in its domestic state, and that assumes no business from any other insurer;

(B) An insurance holding company system that is required to perform a group capital calculation specified by the United States federal reserve board. The lead state commissioner shall request the calculation from the United States federal reserve board under the terms of information sharing agreements in effect. If the United States federal reserve board cannot share the calculation with the lead state commissioner, the insurance holding company system is not exempt from the group capital calculation filing;

(C) An insurance holding company system whose non-United States group wide supervisor is located within a reciprocal jurisdiction as described in W.S. 26-5-112(j)(ii) that recognizes the United States state regulatory approach to group supervision and group capital;

(D) An insurance holding company system:

(I) That provides information to the lead state that meets the requirements for accreditation under the NAIC financial standards and accreditation program, either directly or indirectly through the group wide supervisor, who has determined such information is satisfactory to allow the lead state to comply with the NAIC group supervision approach, as detailed in the NAIC financial analysis handbook; and

(II) Whose non-United States group wide supervisor who is not in a reciprocal jurisdiction recognizes and accepts, as specified by the commissioner in regulation, the group capital calculation as the world wide group capital assessment for United States insurance groups who operate in that jurisdiction.

(ii) Notwithstanding subparagraphs (i)(C) and (D) of this subsection, a lead state commissioner shall require the group capital calculation for United States operations of any non-United States based insurance holding company system where, after any necessary consultation with other supervisors or officials, it is deemed appropriate by the lead state commissioner for prudential oversight and solvency monitoring purposes or for ensuring the competitiveness of the insurance marketplace;

(iii) Notwithstanding the exemptions from filing the group capital calculation stated in subparagraphs (i)(A) through (D) of this subsection, the lead state commissioner has the discretion to exempt the ultimate controlling person from filing the annual group capital calculation or to accept a limited group capital filing or report in accordance with criteria as specified by the commissioner in regulation;

(iv) If the commissioner determines that an insurance holding company system no longer meets one (1) or more of the requirements for an exemption from filing the group capital calculation under this subsection, the insurance holding company system shall file the group capital calculation at the next annual filing date unless given an extension by the lead state commissioner based on reasonable grounds shown.

(q) The ultimate controlling person of every insurer subject to registration and also scoped into the NAIC liquidity stress test framework shall file the results of a specific year's liquidity stress test. The filing shall be made to the lead state insurance commissioner of the insurance holding company system as determined by the procedures within the

financial analysis handbook adopted by the NAIC, subject to the following:

(i) The NAIC liquidity stress test framework shall include scope criteria applicable to a specific data year. These scope criteria shall be reviewed at least annually by the financial stability task force or its successor. Any change to the NAIC liquidity stress test framework or to the data year for which the scope criteria are to be measured shall be effective on January 1 of the year following the calendar year when the changes are adopted. Insurers meeting at least one (1) threshold of the scope criteria are considered scoped into the NAIC liquidity stress test framework for the specified data year unless the lead state insurance commissioner, in consultation with the NAIC financial stability task force or its successor, determines the insurer should not be scoped into the framework for that data year. Similarly, insurers that do not trigger at least one (1) threshold of the scope criteria shall be considered scoped out of the NAIC liquidity stress test framework for the specified data year, unless the lead state insurance commissioner, in consultation with the NAIC financial stability task force or its successor, determines the insurer should be scoped into the framework for that data year;

(ii) The performance of, and filing of the results from, a specific year's liquidity stress test shall comply with the NAIC liquidity stress test framework's instructions and reporting templates for that year and any lead state insurance commissioner determinations, in conjunction with the financial stability task force or its successor, provided within the framework.

26-44-105. Transactions within a holding company system.

(a) Transactions within an insurance holding company system to which an insurer subject to registration is a party shall be subject to the following standards:

(i) The terms shall be fair and reasonable;

(ii) Charges or fees for services performed shall be reasonable;

(iii) Expenses incurred and payment received shall be allocated to the insurer in conformity with customary insurance accounting practices consistently applied;

(iv) The books, accounts and records of each party to all the transactions shall be so maintained as to clearly and accurately disclose the nature and details of the transactions including any accounting information necessary to support the reasonableness of the charges or fees to the respective parties;

(v) The insurer's surplus as regards policy holders following any dividends or distributions to shareholder affiliates shall be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs as set forth in W.S. 26-44-108; and

(vi) Agreements for cost sharing services and management shall include provisions as required by regulation issued by the commissioner.

(b) The following transactions involving a domestic insurer and any person in its insurance holding company system, including amendments or modifications of affiliate agreements previously filed pursuant to this section, which are subject to any materiality standards contained in subsection (b) of this section, shall not be entered into unless the insurer has notified the commissioner in writing of its intention to enter into the transaction at least thirty (30) days prior to the transaction or a shorter period as the commissioner may permit and the commissioner has not disapproved it within that period. The notice for amendments or modifications shall include the reasons for the change and the financial impact on the domestic insurer. Informal notice shall be reported, within thirty (30) days after a termination of a previously filed agreement, to the commissioner for determination of the type of filing required, if any. In assessing transactions under this subsection, the commissioner shall consider whether the transactions comply with subsection (a) of this section and whether they may adversely affect the interests of policyholders. The transactions to be considered are:

(i) Sales, purchases, exchanges, loans or extensions of credit, guarantees or investments if on December 31 of the year immediately preceding the transactions are equal to or exceed:

(A) With respect to nonlife insurers, the lesser of three percent (3%) of the insurer's admitted assets or twenty-five percent (25%) of surplus as regards policyholders;

(B) With respect to life insurers, three percent (3%) of the insurer's admitted assets.

(ii) Loans or extensions of credit to any person who is not an affiliate, where the insurer makes the loans or extensions of credit with the agreement or understanding that the proceeds of the transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to purchase assets of, or to make investments in, any affiliate of the insurer making the loans or extensions of credit if on December 31 of the year immediately preceding the transactions are equal to or exceed:

(A) With respect to nonlife insurers, the lesser of three percent (3%) of the insurer's admitted assets or twenty-five percent (25%) of surplus as regards policyholders;

(B) With respect to life insurers, three percent (3%) of the insurer's admitted assets.

(iii) Reinsurance agreements or modifications thereto, including all reinsurance pooling agreements, agreements in which the reinsurance premium or a change in the insurer's liabilities, or the projected reinsurance premium or a change in the insurer's liabilities in any of the next three (3) years, equals or exceeds five percent (5%) of the insurer's surplus as regards policyholders, as of December 31 of the year immediately preceding, including those agreements which may require as consideration the transfer of assets from an insurer to a nonaffiliate, if an agreement or understanding exists between the insurer and nonaffiliate that any portion of the assets will be transferred to one (1) or more affiliates of the insurer;

(iv) All management agreements, service contracts, tax allocation agreements and all cost-sharing arrangements; and

(v) Any material transactions, specified by regulation, which the commissioner determines may adversely affect the interests of the insurer's policyholders.

(c) Nothing in this section shall be deemed to authorize or permit any transaction which, in the case of an insurer not a member of the same insurance holding company system, would be otherwise contrary to law.

(d) A domestic insurer shall not enter into transactions which are part of a plan or series of like transactions with persons within the insurance holding company system if the purpose of those separate transactions is to avoid the notification requirement set forth in subsection (b) of this section and thus the review that would otherwise occur. If the commissioner determines that separate transactions were entered into over any twelve (12) month period for that purpose, the commissioner may exercise his authority under W.S. 26-44-113.

(e) The commissioner shall be notified within thirty (30) days of any investment of the domestic insurer in any one (1) corporation if the total investment in the corporation by the insurance holding company system exceeds ten percent (10%) of the corporation's voting securities.

26-44-106. Dividends and other distributions.

(a) A domestic insurer shall not pay any extraordinary dividend or make any other extraordinary distribution to its shareholders until thirty (30) days after the commissioner has received notice of the declaration of dividend and has not disapproved payment, or the commissioner has approved the payment whichever is shorter.

(b) For purposes of this section, an extraordinary dividend or distribution includes any dividend or distribution of cash or other property, whose fair market value together with that of other dividends or distributions made within the preceding twelve (12) months exceeds the lesser of:

(i) Ten percent (10%) of the insurer's surplus as regards policyholders as of December 31 of the year immediately preceding; or

(ii) The net gain from operations of the insurer, if the insurer is a life insurer, or the net income, if the insurer is not a life insurer, not including realized capital gains, for the twelve (12) month period ending December 31 of the year immediately preceding, nor pro rata distributions of the insurer's own securities.

(c) In determining whether a dividend or distribution is extraordinary, an insurer other than a life insurer may carry forward net income from the previous two (2) calendar years that has not already been paid out as dividends. This carry-forward shall be computed by taking the net income from the second and

third preceding calendar years, not including realized capital gains, less dividends paid in the second and immediate preceding calendar years.

(d) Notwithstanding any other provision of law, an insurer may declare an extraordinary dividend or distribution which is conditional upon the commissioner's approval. This declaration shall confer no rights upon shareholders until the commissioner has approved the payment or the commissioner has not disapproved the payment within thirty (30) days, whichever is shorter.

26-44-107. Management of domestic insurers subject to registration.

(a) The officers and directors of the insurer are not relieved of any obligation or liability to which they would otherwise be subject by law because the control of the domestic insurer lies with any other person. The insurer shall be managed to assure its separate operating identity consistent with this title.

(b) Nothing in this act shall preclude a domestic insurer from having or sharing a common management or cooperative or joint use of personnel, property or services with one (1) or more other persons under arrangements meeting the standards of W.S. 26-44-105(a).

26-44-108. Adequacy of surplus.

(a) For purposes of this act, in determining whether an insurer's surplus as regards policyholders is reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs, the following factors, among others, shall be considered:

(i) The size of the insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force and other appropriate criteria;

(ii) The extent to which the insurer's business is diversified among the several lines of insurance;

(iii) The number and size of risks insured in each line of business;

(iv) The extent of the geographical dispersion of the insurer's insured risks;

(v) The nature and extent of the insurer's reinsurance program;

(vi) The quality, diversification and liquidity of the insurer's investment portfolio;

(vii) The recent past and projected future trend in the size of the insurer's investment portfolio;

(viii) The surplus as regards policyholders maintained by other comparable insurers;

(ix) The adequacy of the insurer's reserves; and

(x) The quality and liquidity of investments in affiliates.

(b) The commissioner may treat any investment as a disallowed asset for purposes of determining the adequacy of surplus as regards policyholders whenever he deems that treatment necessary.

26-44-109. Examination.

(a) The commissioner may examine any insurer registered under W.S. 26-44-104 or any affiliate of the insurer in accordance with this section and the provisions of W.S. 26-2-116 through 26-2-124 to ascertain the financial condition of the insurer, including the enterprise risk to the insurer by the ultimate controlling party, or by any entity or combination of entities within the insurance holding company system, or by the insurance holding company system on a consolidated basis. The commissioner may retain at the insurer's expense any attorneys, actuaries, accountants and other experts not otherwise a part of the commissioner's staff reasonably necessary to conduct the examination. Any person so retained shall be under the direction and control of the commissioner and shall act in a purely advisory capacity.

(b) To determine compliance with this chapter, the commissioner may order any insurer registered under W.S. 26-44-104 to produce information not in the possession of the insurer if the insurer can obtain access to this information pursuant to contractual relationships, statutory obligations or other method. In the event the insurer cannot obtain the information requested by the commissioner, the insurer shall

provide the commissioner a detailed explanation of the reason that the insurer cannot obtain the information and the identity of the holder of the information. Whenever it appears to the commissioner that the detailed explanation is without merit, the commissioner may, after notice and hearing, suspend or revoke the insurer's license or certificate.

(c) In the event the insurer fails to comply with an order, the commissioner shall have the power to examine the affiliates to obtain the information. The commissioner shall also have the power to issue subpoenas, to administer oaths and to examine under oath any person for purposes of determining compliance with this section. Upon the failure or refusal of any person to obey a subpoena, the commissioner may petition a court of competent jurisdiction, and upon proper showing, the court may enter an order compelling the witness to appear and testify or produce documentary evidence.

26-44-110. Confidential treatment.

(a) All information, documents and copies of the documents and information obtained by or disclosed to the commissioner or any other person in the course of an examination made pursuant to W.S. 26-44-109 and all information reported pursuant to W.S. 26-44-103(b)(xii) and (xiii), 26-44-104 through 26-44-108 and 26-44-119 shall be confidential, shall not be subject to subpoena and shall not be disclosed by the commissioner, the National Association of Insurance Commissioners, or any person, except as authorized by and in accordance with the provisions of W.S. 26-2-113(d), without the prior written consent of the insurer to which the information pertains. The commissioner, after giving the insurer and its affiliates notice and opportunity to be heard, may determine that the interest of policyholders, shareholders or the public will be served by the publication of the information, in which event he may publish all or any part of the information as he deems appropriate, except as provided in this paragraph. The following shall apply to information reported and provided to the department of insurance pursuant to W.S. 26-44-104(p) and (q):

(i) For purposes of the information reported and provided to the department of insurance pursuant to W.S. 26-44-104(p), the commissioner shall maintain the confidentiality of the group capital calculation and group capital ratio produced within the calculation and any group capital information received from an insurance holding company supervised by the

United States federal reserve board or any United States group wide supervisor;

(ii) For purposes of the information reported and provided to the department of insurance pursuant to W.S. 26-44-104(q), the commissioner shall maintain the confidentiality of the liquidity stress test results and supporting disclosures and any liquidity stress test information received from an insurance holding company supervised by the United States federal reserve board and non-United States group wide supervisors.

(b) Neither the commissioner nor any person who received documents, materials or other information while acting under the authority of the commissioner or with whom the documents, materials or other information are shared pursuant to this act shall be permitted or required to testify in any private civil action concerning any confidential documents, materials or information subject to subsection (a) of this section.

(c) Notwithstanding W.S. 26-2-113, the commissioner shall only share confidential and privileged documents, material or information reported pursuant to W.S. 26-44-104(n) with commissioners of states having statutes or regulations substantially similar to Wyoming insurance statutes and who have agreed in writing not to disclose the information.

(d) In addition to any other authorities provided by law, the commissioner shall enter into written agreements with the NAIC governing sharing and use of information provided pursuant to this act consistent with this subsection which shall:

(i) Specify procedures and protocols regarding the confidentiality and security of information shared with the NAIC or a third-party consultant designated by the commissioner pursuant to this act, including procedures and protocols for sharing by the NAIC with other state, federal or international regulators. The agreement shall provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the documents, materials or other information and has verified in writing the legal authority to maintain such confidentiality;

(ii) Specify that ownership of information shared with the NAIC or a third-party consultant designated by the commissioner pursuant to this act remains with the commissioner and the NAIC's or a third-party consultant as designated by the

commissioner's use of the information is subject to the direction of the commissioner;

(iii) Require prompt notice to be given to an insurer whose confidential information in the possession of the NAIC or a third-party consultant designated by the commissioner pursuant to this act is subject to a request or subpoena to the NAIC or a third-party consultant designated by the commissioner for disclosure or production;

(iv) Require the NAIC or a third-party consultant designated by the commissioner to consent to intervention by an insurer in any judicial or administrative action in which the NAIC or a third-party consultant designated by the commissioner may be required to disclose confidential information about the insurer shared with the NAIC or a third-party consultant designated by the commissioner pursuant to this chapter;

(v) Excluding documents, material or information reported pursuant to W.S. 26-44-104(q), prohibit the NAIC or third-party consultant designated by the commissioner from storing the information shared pursuant to this act in a permanent database after the underlying analysis is completed;

(vi) For documents, material or information reported pursuant to W.S. 26-44-104(q), in the case of an agreement involving a third-party consultant designated by the commissioner, provide for notification of the identity of the third-party consultant designated by the commissioner to the applicable insurers.

(e) The sharing of information by the commissioner pursuant to this chapter shall not constitute a delegation of regulatory authority or rulemaking and the commissioner is solely responsible for the administration, execution and enforcement of the provisions of this chapter.

(f) No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the commissioner under this chapter or as a result of sharing as authorized under this chapter.

(g) Documents, materials or other information in the possession or control of the NAIC or a third-party consultant designated by the commissioner pursuant to this chapter shall be confidential by law and privileged, shall not be a public record

under W.S. 16-4-201 through 16-4-205, shall not be subject to subpoena and shall not be subject to discovery or admissible in evidence in any private civil action.

26-44-111. Rules and regulations.

The commissioner may promulgate reasonable rules and regulations and issue orders necessary to carry out the purposes of this act.

26-44-112. Injunctions; prohibitions against voting securities; sequestration of voting securities.

(a) Whenever it appears to the commissioner that any insurer or any director, officer, employee or agent of the insurer has committed or is about to commit a violation of this act or of any rule, regulation or order issued by the commissioner pursuant to this act, the commissioner may apply to the district court for the county in which the principal office of the insurer is located or, if the insurer has no office in this state, then to the district court for Laramie county for an injunction.

(b) No security which is the subject of any agreement or arrangement regarding acquisition, or which is acquired or to be acquired, in violation of this act or of any rule, regulation or order issued by the commissioner pursuant to this act may be voted at any shareholder's 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. No action taken at any meeting shall be invalidated by the voting of the securities, unless the action would materially affect control of the insurer or unless the Wyoming courts have so ordered. If an insurer or the commissioner has reason to believe that any security of the insurer has been or is about to be acquired in violation of this act or of any rule, regulation or order issued by the commissioner pursuant to this act, the insurer or the commissioner may apply to the court for the county in which the insurer has its principle place of business to enjoin any action violating this act, to enjoin the voting of any security acquired in violation of this act, to void any vote of such a security already cast at any meeting of shareholders and for other equitable relief.

(c) In any case where a person has acquired or is proposing to acquire any voting securities in violation of this

act or any rule, regulation or order issued by the commissioner, the commissioner or insurer may request the district court to seize or sequester any voting securities of the insurer owned directly or indirectly by the person, and issue an order appropriate to carry out the purposes of this act. Notwithstanding any other provisions of law, for the purposes of this act the sites of the ownership of the securities of domestic insurers shall be deemed to be in Wyoming.

26-44-113. Sanctions.

(a) Any insurer failing, without just cause, to file any registration statement as required in this act shall be required, after notice and hearing, to pay a penalty of five hundred dollars ($500.00) for each day's delay, to be recovered by the commissioner. The penalty recovered shall be paid into the general fund. The commissioner may reduce the penalty if the insurer demonstrates to the commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.

(b) Any director or officer of an insurance holding company system who knowingly violates, participates in, or assents to, or who knowingly permits any of the officers or agents of the insurer to engage in transactions or make investments which violate this act is guilty of a misdemeanor punishable by a fine of not more than one thousand dollars ($1,000.00), imprisonment for not more than one (1) year, or both.

(c) Whenever it appears to the commissioner that any insurer subject to this act or any director, officer, employee or agent of the insurer has engaged in any transaction or entered into a contract which is subject to this act and which would not have been approved had approval been requested, the commissioner may order the insurer to cease and desist immediately any further activity under that transaction or contract. After notice and hearing the commissioner may also order the insurer to void any contracts and restore the status quo if the action is in the best interest of the policyholders, creditors or the public.

(d) Any officer, director or employee of an insurance holding company system who willfully and knowingly subscribes to or makes or causes to be made any false statements or false reports or false filings with the intent to deceive the commissioner in the performance of his duties under this article

is guilty of a felony and shall be fined not more than two hundred fifty thousand dollars ($250,000.00), imprisoned for not more than ten (10) years, or both.

(e) Whenever it appears to the commissioner that any person has committed a violation of W.S. 26-44-103 which prevents the full understanding of the enterprise risk to the insurer by affiliates or by the insurance holding company system, the violation may serve as an independent basis for disapproving dividends or distributions and for placing the insurer under an order in accordance with chapter 28 of this title.

26-44-114. Receivership.

Whenever it appears to the commissioner that any person has committed a violation of this act which so impairs the financial condition of a domestic insurer as to threaten insolvency or make the further transaction of business by the person not in the best interest of the policyholders, creditors, shareholders or the public, then the commissioner may proceed as provided in chapter 28 of this title.

26-44-115. Recovery.

(a) Subject to subsections (b), (c) and (d) of this section, if an order for liquidation or rehabilitation of a domestic insurer has been entered, the receiver appointed under the order shall have a right to recover on behalf of the insurer any distribution or payment made at any time during the one (1) year preceding the petition for liquidation, conservation or rehabilitation which is either:

(i) From any parent corporation or holding company or person or affiliate who otherwise controlled the insurer, the amount of distributions other than distributions of shares of the same class of stock paid by the insurer on its capital stock; or

(ii) Any payment in the form of a bonus, termination settlement or extraordinary lump sum salary adjustment made by the insurer or its subsidiary to a director, officer or employee.

(b) A distribution shall not be recoverable if the parent or affiliate 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 a parent corporation or holding company or a person who otherwise controlled the insurer or affiliate at the time the distributions were paid shall be liable up to the amount of distributions or payments the person received under subsection (a) of this section. Any person who otherwise controlled the insurer at the time the distributions were declared shall be liable up to the amount of distributions he would have received if they had been paid immediately.

(d) The maximum amount recoverable under this section shall be the amount needed in excess of all other available assets of the impaired or insolvent insurer to pay the contractual obligations of the impaired or insolvent insurer and to reimburse any guaranty funds.

(e) To the extent that any person liable under subsection (c) of this section is insolvent or otherwise fails to pay claims due from it pursuant to subsection (c) of this section, its parent corporation or holding company or person who otherwise controlled it at the time the distribution was paid, shall be liable for any resulting deficiency in the amount recovered from the parent corporation or holding company or person who otherwise controlled it.

26-44-116. Revocation, suspension or nonrenewal of insurer's license.

Whenever it appears to the commissioner that any person has committed a violation of this act which makes the continued operation of an insurer contrary to the interests of policyholders or the public, the commissioner may, after giving notice and an opportunity for hearing, determine to suspend, revoke or refuse to renew the insurer's license or authority to do business in Wyoming for any period he finds is required for the protection of policyholders or the public. The determination shall be accompanied by specific findings of fact and conclusions of law.

26-44-117. Judicial review.

Any person aggrieved or adversely affected in fact by any final decision, order, ruling, finding or other act of the insurance commissioner made pursuant to this chapter may obtain judicial

review in accordance with the Wyoming Administrative Procedure Act.

26-44-118. Supervisory colleges.

(a) With respect to any insurer registered under W.S. 26-44-104, and in accordance with subsection (c) of this section, the commissioner shall also have the power to participate in a supervisory college for any domestic insurer that is part of an insurance holding company system with international operations in order to determine compliance by the insurer with this chapter. The powers of the commissioner with respect to supervisory colleges include, but are not limited to, the following:

(i) Initiating the establishment of a supervisory college;

(ii) Clarifying the membership and participation of other supervisors in the supervisory college;

(iii) Clarifying the functions of the supervisory college and the role of other regulators, including the establishment of a group-wide supervisor;

(iv) Coordinating the ongoing activities of the supervisory college, including planning meetings, supervisory activities, and processes for information sharing; and

(v) Establishing a crisis management plan.

(b) Each registered insurer subject to this section shall be liable for and shall pay the reasonable expenses of the commissioner's participation in a supervisory college in accordance with subsection (c) of this section, including reasonable travel expenses. For purposes of this section, a supervisory college may be convened as either a temporary or permanent forum for communication and cooperation between the regulators charged with the supervision of the insurer or its affiliates, and the commissioner may establish a regular assessment to the insurer for the payment of these expenses.

(c) In order to assess the business strategy, financial position, legal and regulatory position, risk exposure, risk management and governance processes, and as part of the examination of individual insurers in accordance with W.S. 26-44-109, the commissioner may participate in a supervisory

college with other regulators charged with supervision of the insurer or its affiliates, including other state, federal and international regulatory agencies. The commissioner may enter into agreements providing the basis for cooperation between the commissioner and the other regulatory agencies, and the activities of the supervisory college. Nothing in this section shall delegate to the supervisory college the authority of the commissioner to regulate or supervise the insurer or its affiliates within his jurisdiction.

26-44-119. Group wide supervision of internationally active insurance groups.

(a) The commissioner is authorized to act as the group wide supervisor for any internationally active insurance group in accordance with this section. However, the commissioner may acknowledge a regulatory official from another jurisdiction as the group wide supervisor for an internationally active insurance group where the internationally active insurance group:

(i) Does not have substantial insurance operations in the United States;

(ii) Has substantial insurance operations in the United States, but not in Wyoming; or

(iii) Has substantial insurance operations in the United States and Wyoming, but the commissioner has determined pursuant to the factors set forth in subsections (c) and (j) of this section that the other regulatory official is the appropriate group wide supervisor.

(b) An insurance holding company system that is not an internationally active insurance group may request that the commissioner make a determination or acknowledgement as to a group wide supervisor pursuant to this section.

(c) In cooperation with other state, federal and international regulatory agencies, the commissioner shall identify one (1) group wide supervisor for an internationally active insurance group. The commissioner may determine that the commissioner is the appropriate group wide supervisor for an internationally active insurance group that conducts substantial insurance operations concentrated in Wyoming. However, the commissioner may acknowledge that a regulatory official from another jurisdiction is the appropriate group wide supervisor

for the internationally active insurance group. The commissioner shall consider the following factors when making a determination or acknowledgment:

(i) The place of domicile of the insurers within the internationally active insurance group that hold the largest share of the group's written premiums, assets or liabilities;

(ii) The place of domicile of the top tiered insurer in the insurance holding company system of the internationally active insurance group;

(iii) The location of the executive offices or largest operational offices of the internationally active insurance group;

(iv) Whether another regulatory official seeks to act as the group wide supervisor under a regulatory system the commissioner determines:

(A) To be substantially similar to the system of regulation provided under the laws of Wyoming; or

(B) Sufficiently provides group wide supervision, enterprise risk analysis and cooperation with other regulatory officials.

(v) Whether another regulatory official provides the commissioner with reasonably reciprocal recognition and cooperation.

(d) If the commissioner is identified under this section as the group wide supervisor, the commissioner may determine that it is appropriate to acknowledge another supervisor to serve as the group wide supervisor. The acknowledgment of the group wide supervisor shall be made after consideration of the factors listed in paragraphs (c)(i) through (v) of this section and shall be made in cooperation with and subject to the acknowledgment of other regulatory officials involved with supervision of members of the internationally active insurance group and in consultation with the internationally active insurance group.

(e) Notwithstanding any other provision of law, when a regulatory official, other than the commissioner, is acting as the group wide supervisor of an internationally active insurance group, the commissioner shall acknowledge that regulatory

official as the group wide supervisor. However, the commissioner shall make a determination or acknowledgement under subsection (c) or (d) of this section as to the appropriate group wide supervisor for an internationally active insurance group if a material change in the internationally active insurance group results in either of the following:

(i) The internationally active insurance group's insurers domiciled in Wyoming holding the largest share of the group's premiums, assets or liabilities;

(ii) Wyoming being the place of domicile of the top tiered insurer in the internationally active insurance group's insurance holding company system.

(f) Pursuant to W.S. 26-44-109, the commissioner may collect from any insurer registered under W.S. 26-44-104 all information necessary to determine whether the commissioner may act as the group wide supervisor of an internationally active insurance group or if the commissioner may acknowledge another regulatory official to act as the group wide supervisor. Prior to issuing a determination that an internationally active insurance group is subject to group wide supervision by the commissioner, the commissioner shall notify the insurer registered pursuant to W.S. 26-44-104 and the ultimate controlling person within the internationally active insurance group. The internationally active insurance group shall have not less than thirty (30) days from the date of notification to provide the commissioner with additional information pertinent to the pending determination.

(g) The commissioner shall publish on the department's website the identity of each internationally active insurance group that the commissioner has determined is subject to group wide supervision by the commissioner.

(h) If the commissioner is the group wide supervisor for an internationally active insurance group, the commissioner may do any of the following:

(i) Assess the enterprise risks within the internationally active insurance group to ensure that:

(A) The material financial condition and liquidity risks to the members of the internationally active insurance group that are engaged in the business of insurance are identified by management; and

(B) Reasonable and effective mitigation measures are in place to address the identified enterprise risks.

(ii) Request from any member of an internationally active insurance group subject to the commissioner's supervision information necessary and appropriate to assess enterprise risk including information about the members of the internationally active insurance group regarding any of the following:

(A) Governance, risk assessment and management;

(B) Capital adequacy; and

(C) Material intercompany transactions.

(iii) Coordinate and, through the authority of the regulatory officials of the jurisdictions where members of the internationally active insurance group are domiciled, compel development and implementation of reasonable measures designed to ensure that the internationally active insurance group is able to timely recognize and mitigate enterprise risks to members of the internationally active insurance group that are engaged in the business of insurance;

(iv) Subject to the confidentiality provisions of W.S. 26-44-110, communicate with other state, federal and international regulatory agencies for members within the internationally active insurance group and share relevant information through supervisory colleges as set forth in W.S. 26-44-118 or otherwise;

(v) Enter into agreements with or obtain documentation from any insurer registered under W.S. 26-44-104, any member of the internationally active insurance group or any other state, federal or international regulatory agency on behalf of members of the internationally active insurance group that provide the basis for or otherwise clarify the commissioner's role as group wide supervisor, including provisions for resolving disputes with other regulatory officials. The agreements or documentation shall not serve as evidence in any proceeding that any insurer or person within an insurance holding company system not domiciled or incorporated in Wyoming is doing business in Wyoming or is otherwise subject to the jurisdiction of the state of Wyoming;

(vi) Conduct any other group wide supervision activities consistent with this section as deemed necessary by the commissioner.

(j) If the commissioner acknowledges that another regulatory official from a jurisdiction that is not accredited by the NAIC is the group wide supervisor of an internationally active insurance group, the commissioner may reasonably cooperate through a supervisory college or otherwise with group wide supervision undertaken by the group wide supervisor, provided that:

(i) The commissioner's cooperation complies with the laws of Wyoming; and

(ii) The regulatory official acknowledged as the group wide supervisor also recognizes and cooperates with the commissioner's activities as a group wide supervisor for other internationally active insurance groups as applicable. Where the recognition and cooperation is not reasonably reciprocal, the commissioner may refuse recognition and cooperation.

(k) The commissioner may enter into agreements with or obtain documentation from any insurer registered under W.S. 26-44-104, any affiliate of the insurer or any other state, federal or international regulatory agencies for members of the internationally active insurance group that provide the basis for or otherwise clarify a regulatory official's role as group wide supervisor.

(m) A registered insurer subject to this section shall be liable for and shall pay the reasonable expenses of the commissioner's participation in the administration of this section, including the costs to engage attorneys, actuaries or other professionals and all reasonable travel costs.

26-44-120. Authorized use of and prohibited statements regarding group capital calculations, liquidity stress tests and related information.

(a) The group capital calculation, including the group capital ratio produced within the calculation, that is required to be reported under W.S. 26-44-104(p) and the liquidity stress test along with its results and supporting disclosures required under W.S. 26-44-104(q) may be used as regulatory tools for assessing group risks and capital adequacy and group liquidity

risks, respectively, but shall not be used to rank insurers or insurance holding company systems generally.

(b) Except as authorized in subsection (d) of this section or as otherwise required in this act, a person shall not engage in the 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 or television station or any electronic means of communication available to the public, or in any other way an advertisement, announcement or statement containing a representation or statement with regard to the group capital calculation, group capital ratio, liquidity stress test results, or supporting disclosures for the liquidity stress test of any insurer or any insurer group, or any component derived in the calculation by any insurer, broker or other person engaged in any manner in the insurance business.

(c) Any action prohibited under subsection (b) of this section shall be deemed by the commissioner to be misleading.

(d) If any materially false statement with respect to the group capital calculation, group capital ratio, liquidity stress test result or supporting disclosures for the liquidity stress test or an inappropriate comparison of any amount to an insurer's or insurance group's group capital calculation, group capital ratio, liquidity stress test result or supporting disclosures is published in any written publication and the insurer is able to demonstrate to the commissioner with substantial proof the falsity of the statement or the inappropriateness of the comparison, then the insurer may publish announcements in a written publication if the sole purpose of the announcement is to rebut the materially false statement or inappropriate comparison.

CHAPTER 45 - BROKER CONTROLLED INSURERS

26-45-101. Short title.

This article may be cited as the "Broker Controlled Insurer Act."

26-45-102. Definitions.

(a) As used in this article:

(i) "Accredited state" means a state in which the insurance department or regulatory agency has qualified as meeting the minimum financial regulatory standards promulgated and established by the National Association of Insurance Commissioners;

(ii) "Broker" means an insurance broker as defined in W.S. 26-1-102(a)(vi) or any other person, firm, association or corporation, when, for any compensation, commission or other thing of value, the person, firm, association or corporation acts or aids in any manner in soliciting, negotiating or procuring the making of any insurance contract on behalf of an insured other than the person, firm, association or corporation;

(iii) "Control" or "controlled" means as defined in W.S. 26-44-101(a)(iii);

(iv) "Controlled insurer" means a licensed insurer which is controlled, directly or indirectly, by a broker;

(v) "Controlling broker" means a broker who, directly or indirectly, controls an insurer;

(vi) "Independent casualty actuary" means a casualty actuary who is a member in good standing of the American Academy of Actuaries and who is not an employee, principal, or indirect owner of, or in any way controlled by or affiliated with the insurer or broker;

(vii) "Licensed insurer" means any person duly licensed to transact a property or casualty insurance business in this state. The following are not licensed insurers for the purposes of this article:

(A) Risk retention groups as defined in the Wyoming Risk Retention Act;

(B) Residual market pools and joint underwriting authorities or associations; and

(C) Captive insurers. For purposes of this article, captive insurers are insurance companies owned by another organization and whose exclusive purpose is to insure risks of the parent organization and affiliated companies or, in the case of groups and associations, insurance organizations

owned by the insureds whose exclusive purpose is to insure risks of member organizations or group members and their affiliates.

26-45-103. Applicability.

This article shall apply to licensed insurers either domiciled in this state or domiciled in a state that is not an accredited state having in effect a substantially similar law. All provisions of the Insurance Holding Company System Regulatory Act, to the extent they are not superseded by this article, shall continue to apply to all parties within holding company systems subject to this article.

26-45-104. Minimum standards.

(a) The provisions of this section shall apply if, in any calendar year, the aggregate amount of gross written premium on business placed with a controlled insurer by a controlling broker is equal to or greater than five percent (5%) of the admitted assets of the controlled insurer, as reported in the controlled insurer's quarterly statement filed as of September 30 of the prior year.

(b) Notwithstanding subsection (a) of this section, the provisions of this section shall not apply if:

(i) The controlled insurer, except for insurance business written through a residual market facility such as the Wyoming Assigned Risk Plan, accepts insurance business only from a controlling broker, a broker controlled by the controlled insurer, or a broker that is a subsidiary of the controlled insurer; and

(ii) The controlling broker:

(A) Places insurance only with the controlled insurer, or only with the controlled insurer and a member or members of the controlled insurer's holding company system, or the controlled insurer's parent, affiliate or subsidiary and receives no compensation based upon the amount of premiums written in connection with the insurance placed; and

(B) Accepts insurance placements only from nonaffiliated subproducers, and not directly from insureds.

(c) The controlled insurer shall not accept business from a controlling broker and a controlling broker shall not place

business with a controlled insurer except pursuant to a written contract, which has been approved by the board of directors of the insurer. The contract shall be subject to the following requirements:

(i) A domestic controlled insurer shall file the contract with, and obtain the approval of, the commissioner prior to the effective date of the contract and in accordance with W.S. 26-15-110(b) and 26-15-111. In all other cases the insurer shall file the contract, or any amendment to a contract, with the commissioner within fifteen (15) days after it has been signed;

(ii) The contract shall specify the responsibilities of each party and contain the following minimum provisions:

(A) The controlled insurer may terminate the contract for cause upon written notice to the controlling broker. The controlled insurer shall suspend the authority of the controlling broker to write business during the pendency of any dispute regarding the cause for the termination;

(B) The controlling broker shall render accounts to the controlled insurer detailing all material transactions, including information necessary to support all commissions, charges and other fees received by, or owing to, the controlling broker;

(C) The controlling broker shall remit all funds due under the terms of the contract to the controlled insurer on at least a monthly basis. The due date shall be fixed so that premiums collected from the insured shall be remitted no later than ninety (90) days after the effective date of the policy;

(D) All funds collected for the controlled insurer's account shall be held by the controlling broker in a fiduciary capacity in accordance with W.S. 26-9-229, in one (1) or more appropriately identified bank accounts in banks that are organized or licensed under the laws of the United States or any state and are insured by an instrumentality of the United States government and have been determined by either the insurance commissioner or the securities valuation office of the National Association of Insurance Commissioners to meet such standards of financial condition and standing as are considered necessary and appropriate. Funds of a controlling broker not required to be licensed in this state shall be maintained in compliance with

the requirements of the controlling broker's domiciliary jurisdiction;

(E) The controlling broker shall maintain separately identifiable records of business written for the controlled insurer;

(F) The contract shall not be assigned in whole or in part by the controlling broker;

(G) The controlled insurer shall provide the controlling broker with its underwriting standards, rules and procedures, manuals setting forth the rates to be charged, and the conditions for the acceptance or rejection of risks. The controlling broker shall adhere to the standards, rules, procedures, rates and conditions. The standards, rules, procedures, rates and conditions shall be the same as those applicable to comparable business placed with the controlled insurer by a broker other than the controlling broker;

(H) The rates and terms of the controlling broker's commissions, charges or other fees and the purposes for those charges or fees shall be defined in the contract and shall be no greater than those applicable to comparable business placed with the controlled insurer by brokers other than controlling brokers. For purposes of this subsection, "comparable business" includes but is not limited to the same lines of insurance, same kinds of insurance, similar policy limits, similar types of risk and similar quality of business;

(J) If the contract provides that the controlling broker, on insurance business placed with the insurer, is to be compensated contingent upon the insurer's profits on that business, then the compensation shall not be determined and paid until:

(I) The adequacy of the controlled insurer's reserves on remaining claims has been independently verified pursuant to subsection (e) of this section; and

(II) For casualty insurance, at least five (5) years after the premiums are earned; and

(III) On any other insurance, at least one (1) year after the premiums are earned.

(K) The contract shall place a limit on the controlling broker's writings in relation to the controlled insurer's surplus and total writings. The insurer may establish a different limit for each line or subline of business. The controlled insurer shall notify the controlling broker when the applicable limit is approached and shall not accept business from the controlling broker if the limit is reached. The controlling broker shall not place business with the controlled insurer if it has been notified by the controlled insurer that the limit has been reached; and

(M) The controlling broker may negotiate but shall not bind reinsurance on behalf of the controlled insurer on business the controlling broker places with the controlled insurer.

(d) Every controlled insurer shall have an audit committee of the board of directors composed of independent directors. The audit committee shall annually meet with management, the insurer's independent certified public accountants, and an independent casualty actuary or other independent loss reserve specialist acceptable to the commissioner to review the adequacy of the insurer's loss reserves.

(e) In addition to any other required loss reserve certification, the controlled insurer shall annually, on April 1 of each year, file with the commissioner an opinion of an independent casualty actuary or other independent loss reserve specialist acceptable to the commissioner reporting loss ratios for each line of business written and attesting to the adequacy of loss reserves established for losses incurred and outstanding as of year-end, including losses incurred but not reported, on business placed by the broker.

(f) The controlled insurer shall annually file a report with the commissioner showing:

(i) The percentage that the amounts specified in paragraphs (ii) through (iv) of this subsection represent of the controlled insurer's net premiums written for each line of insurance;

(ii) The amount of premiums on insurance business placed with the controlled insurer by the controlling broker;

(iii) The amount of commissions, charges or other fees paid by the controlled insurer to the controlling broker during the previous calendar year; and

(iv) The amounts owed to the controlling broker on the business by line of insurance on the annual statement.

26-45-105. Disclosure.

The controlling broker, prior to the effective date of the policy, shall deliver written notice to the prospective insured disclosing the relationship between the broker and the controlled insurer, except that, if the business is placed through a subproducer who is not a controlling broker, the controlling broker shall retain in his records a signed commitment from the subproducer that the subproducer is aware of the relationship between the insurer and the broker and that the subproducer has or will notify the insured.

26-45-106. Penalties and liabilities.

(a) If the commissioner finds after a hearing conducted in accordance with W.S. 26-2-125 that any person has violated any provision of this article, the commissioner may order any or all of the following:

(i) For each separate violation, a civil penalty not to exceed five thousand dollars ($5,000.00);

(ii) For any controlling broker violating this article, revocation or suspension of the controlling broker's license;

(iii) The controlling broker to reimburse the insurer, the rehabilitator or liquidator of the insurer for any losses incurred by the insurer caused by a violation of this article committed by the controlling broker;

(iv) The controlling broker to cease placing business with the controlled insurer.

(b) Nothing contained in this section shall affect the right of the commissioner to impose any other penalties provided for in this code.

(c) Nothing contained in this section is intended to or shall in any manner limit or restrict the rights of policyholders, claimants, creditors or other third parties.

26-45-107. Rules and regulations.

The commissioner may adopt reasonable rules and regulations for the implementation and administration of this article.

26-45-108. Compliance with this article.

Controlled insurers and controlling brokers shall comply with W.S. 26-45-104 by September 1, 1992, and with W.S. 26-45-105 beginning with all policies written or renewed on or after September 1, 1992.

CHAPTER 46 - MANAGING GENERAL AGENTS

26-46-101. Definitions.

(a) As used in this article:

(i) "Actuary" means a person who is a member in good standing of the American Academy of Actuaries;

(ii) "Managing general agent" means any person, firm, association or corporation that:

(A) Acts as an agent or broker for an insurer whether known as a managing general agent, manager or other similar term;

(B) With or without the authority, either separately or together with affiliates, produces directly or indirectly or underwrites an amount of gross direct written premium equal to or more than five percent (5%) of the surplus as regards policyholders as reported in the last annual statement of the insurer in any one (1) quarter or year; and

(C) Manages all or part of the insurance business of an insurer, including the management of a separate division, department or underwriting office and:

(I) Negotiates reinsurance on behalf of the insurer; or

(II) Adjusts or pays claims.

(iii) "Underwrite" means the authority to accept or reject risk on behalf of the insurer;

(iv) The following persons shall not be considered as "managing general agents":

(A) An employee of the insurer;

(B) A United States manager of the United States branch of an alien insurer;

(C) An underwriting manager:

(I) Which, pursuant to contract, manages all the insurance operations of the insurer;

(II) Is under common control with the insurer, subject to the Insurance Holding Company System Regulatory Act; and

(III) Whose compensation is not based on the volume of premiums written.

(D) The attorney-in-fact authorized by and acting for the subscribers of a reciprocal insurer or interinsurance exchange under powers of attorney.

26-46-102. License required.

(a) No person shall act in the capacity of a managing general agent with respect to risks located in this state for an insurer licensed in this state unless the person is a licensed agent or broker in this state.

(b) No person shall act in the capacity of a managing general agent representing an insurer domiciled in this state with respect to risks located outside this state unless the person is licensed and appointed as an agent or broker in this state.

(c) The commissioner may:

(i) Require a bond from any managing general agent in an amount and from an insurer acceptable to him for the protection of each insurer;

(ii) Require the managing general agent to maintain an errors and omissions policy sufficient to protect the insurer; and

(iii) Impose upon any person acting in the capacity of a managing general agent under subsection (a) or (b) of this section, a biennial fee not to exceed one hundred dollars ($100.00). This fee shall be in addition to any other fees required under this code.

26-46-103. Required contract provisions.

(a) No person acting in the capacity of a managing general agent shall place business with an insurer unless there is in force a written contract between the parties which:

(i) Sets forth the responsibilities of each party;

(ii) Where both parties share responsibility for a particular function, specifies the division of such responsibilities; and

(iii) Contains the following minimum provisions:

(A) The insurer may terminate the contract for cause upon written notice to the managing general agent. The insurer may suspend the underwriting authority of the managing general agent during the pendency of any dispute regarding the cause for termination;

(B) The managing general agent shall render accounts to the insurer detailing all transactions and remit all funds due under the contract to the insurer on not less than a monthly basis;

(C) All funds collected for the account of an insurer shall be held by the managing general agent in a fiduciary capacity in accordance with W.S. 26-9-229 in a financial institution that:

(I) Is organized or licensed under the laws of the United States or any state;

(II) Is insured by an instrumentality of the United States government; and

(III) Has been determined by either the insurance commissioner or the securities valuation office of the National Association of Insurance Commissioners to meet such standards of financial condition and standing as are considered necessary and appropriate.

(D) The account required by subparagraph (C) of this paragraph shall be used for all payments on behalf of the insurer. The managing general agent may retain no more than three (3) months estimated claims payments and allocated loss adjustment expenses. Any payments received by the managing general agent shall be deemed received by the insurer;

(E) Separate records of business written by the managing general agent shall be maintained for the duration of the agreement and three (3) years thereafter. The insurer shall have access and the right to copy all accounts and records related to its business in a form usable by the insurer. The commissioner shall have access to all books, bank accounts and records of the managing general agent in a form usable to the commissioner;

(F) The contract may not be assigned in whole or in part by the managing general agent;

(G) Appropriate underwriting guidelines including:

(I) The maximum annual premium volume;

(II) The basis of the rates to be charged;

(III) The types of risks which may be written;

(IV) Maximum limits of liability;

(V) Applicable exclusions;

(VI) Territorial limitations;

(VII) Policy cancellation provisions; and

(VIII) The maximum policy period.

(H) The insurer shall have the right to cancel or nonrenew any policy of insurance subject to applicable laws and regulations concerning those actions;

(J) If the contract permits the managing general agent to settle claims on behalf of the insurer:

(I) All claims shall be reported to the company in a timely manner;

(II) A copy of the claim file shall be sent to the insurer at its request or as soon as it becomes known that the claim:

1. Has the potential to exceed an amount determined by the commissioner or exceed the limit set by the company, whichever is less;

2. Involves a coverage dispute;

3. May exceed the managing general agent's claims settlement authority;

4. Is open for more than six (6) months; or

5. Is closed by payment exceeding an amount set by the commissioner or an amount set by the company, whichever is less.

(III) All claims files shall be the joint property of the insurer and managing general agent. Upon an order of liquidation of the insurer the files shall become the sole property of the insurer or its estate. The managing general agent shall have reasonable access to and the right to copy the files on a timely basis;

(IV) Any settlement authority granted to the managing general agent may be terminated for cause upon the insurer's written notice to the managing general agent or upon the termination of the contract. The insurer may suspend the settlement authority during the pendency of any dispute regarding the cause for termination.

(K) If the contract provides for a sharing of interim profits by the managing general agent, and the managing general agent has the authority to determine the amount of the profits by establishing loss reserves or controlling claim payments, or by any other manner, interim profits shall not be

paid to the managing general agent until the profits have been verified:

(I) For insurance business other than casualty insurance business, one (1) year after they are earned; and

(II) For casualty insurance business, five (5) years after they are earned.

(M) The managing general agent shall not:

(I) Bind reinsurance or retrocessions on behalf of the insurer;

(II) Commit the insurer to participate in insurance or reinsurance syndicates;

(III) Appoint any agent or broker without assuring that the agent or broker is lawfully licensed to transact the type of insurance for which he is appointed;

(IV) Without prior approval of the insurer, pay or commit the insurer to pay a claim over a specified amount, net of reinsurance, exceeding one percent (1%) of the insurer's surplus as regards policyholders as of December 31 of the last completed calendar year;

(V) Collect any payment from a reinsurer or commit the insurer to any claim settlement with a reinsurer without prior approval of the insurer. If prior approval is given, a report shall be promptly forwarded to the insurer;

(VI) Permit its subproducer to serve on its board of directors or the insurer's board of directors;

(VII) Employ an individual who is employed by the insurer; or

(VIII) Appoint a submanaging general agent.

26-46-104. Duties of insurer.

(a) The insurer shall have on file an independent financial examination, in a form acceptable to the commissioner, of each managing general agent with which it has done business.

(b) If a managing general agent establishes loss reserves, the insurer shall, in addition to any other required loss reserve certification, annually obtain the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the managing general agent.

(c) The insurer shall, at least semiannually, conduct an onsite review of the underwriting and claims processing operation of the managing general agent.

(d) Binding authority for all reinsurance contracts or participation in insurance or reinsurance contracts or participation in insurance or reinsurance syndicates shall rest with an officer of the insurer, who shall not be affiliated with the managing general agent.

(e) Within thirty (30) days of entering into or termination of a contract with a managing general agent, the insurer shall provide written notification of the appointment or termination to the commissioner.

(f) Notices of the appointment of a managing general agent shall include a statement of duties which the applicant is expected to perform on behalf of the insurer, the lines of insurance for which the applicant is to be authorized to act, and any other information the commissioner may request.

(g) An insurer shall review its books and records each quarter to determine if any agent or broker has become, by operation, a managing general agent. If the insurer determines that an agent or broker has become a managing general agent, the insurer shall promptly notify the agent or broker and the commissioner of the determination and the agent or broker and the insurer shall fully comply with the provisions of this article within thirty (30) days.

(h) An insurer shall not appoint to its board of directors an officer, director, employee, subproducer or controlling shareholder of its managing general agents. This section shall not apply to relationships governed by the Insurance Holding Company System Regulatory Act or, if applicable, the Broker Controlled Insurer Act.

26-46-105. Examination authority.

The acts of the managing general agent shall be considered to be the acts of the insurer on whose behalf it is acting. A managing general agent may be examined as if it were the insurer.

26-46-106. Penalties and liabilities.

(a) If the commissioner finds after a hearing conducted in accordance with W.S. 26-2-125 that any person has violated any provision of this article, the commissioner may order:

(i) For each separate violation, a civil penalty not to exceed five thousand dollars ($5,000.00);

(ii) For any agent or broker violating this article, revocation or suspension of the agent's or broker's license; and

(iii) The managing general agent to reimburse the insurer, the rehabilitator or liquidator of the insurer for any losses incurred by the insurer caused by a violation of this article committed by the managing general agent.

(b) Nothing contained in this section shall affect the right of the commissioner to impose any other penalties provided for by this code.

(c) Nothing contained in this article is intended to or shall in any manner limit or restrict the rights of the policyholders, claimants and creditors or other third parties.

26-46-107. Rules and regulations.

The commissioner may adopt reasonable rules and regulations for the implementation and administration of this article.

CHAPTER 47 - REINSURANCE INTERMEDIARIES

26-47-101. Short title.

This article may be cited as the "Reinsurance Intermediary Act."

26-47-102. Definitions.

(a) As used in this article:

(i) "Actuary" means a person who is a member in good standing of the American Academy of Actuaries;

(ii) "Controlling person" means any person who directly or indirectly has the power to direct or cause to be directed, the management, control or activities of the reinsurance intermediary;

(iii) "Licensed producer" means an agent, broker or reinsurance intermediary licensed pursuant to the applicable provisions of this code;

(iv) "Qualified United States financial institution" means an institution that is organized or licensed under the laws of the United States or any state and is insured by an instrumentality of the United States government, and has been determined by either the insurance commissioner or the securities valuation office of the National Association of Insurance Commissioners to meet standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the commissioner;

(v) "Reinsurance intermediary" means a reinsurance intermediary broker or a reinsurance intermediary manager;

(vi) "Reinsurance intermediary broker" means any person, other than an officer or employee of the ceding insurer, who solicits, negotiates or places reinsurance cessions or retrocessions on behalf of a ceding insurer without the authority or power to bind reinsurance on behalf of the ceding insurer;

(vii) "Reinsurance intermediary manager" means any person who has authority to bind or manage all or part of the assumed reinsurance business of a reinsurer, including the management of a separate division, department or underwriting office, and who acts as an agent for the reinsurer whether known as a "reinsurance intermediary manager," "manager" or other similar term. The following persons shall not be considered a reinsurance intermediary manager, with respect to a reinsurer, for the purposes of this article:

(A) An employee of the reinsurer;

(B) A United States manager of the United States branch of an alien reinsurer;

(C) An underwriting manager:

(I) Which pursuant to contract, manages all the reinsurance operations of the reinsurer;

(II) Is under common control with the reinsurer, subject to the Insurance Holding Company System Regulatory Act; and

(III) Whose compensation is not based on the volume of premiums written.

(D) The manager of a group, association, pool or organization of insurers which engage in joint underwriting or joint reinsurance and are subject to examination by the insurance commissioner of the state in which the manager's principal business office is located.

(viii) "Reinsurer" means any person with the authority to assume reinsurance in this state as an insurer pursuant to the applicable provisions of this code;

(ix) "To be in violation" means that the reinsurance intermediary, insurer or reinsurer for whom the reinsurance intermediary was acting failed to substantially comply with the provisions of this article.

26-47-103. License required.

(a) No person shall act as a reinsurance intermediary broker in this state if he maintains an office either directly or as a member, officer, director or employee of a firm, association or corporation:

(i) In this state, unless he is a licensed producer in this state; or

(ii) In another state, unless he:

(A) Is a licensed producer in this state or another state having a law substantially similar to this article; or

(B) Is licensed in this state as a nonresident reinsurance intermediary.

(b) No person shall act as a reinsurance intermediary manager:

(i) For a reinsurer domiciled in this state, unless he is a licensed producer in this state;

(ii) In this state, if he maintains an office either directly or as a member, officer, director or employee of a firm, association or corporation in this state, unless he is a licensed producer in this state;

(iii) In another state for a nondomestic insurer, unless he:

(A) Is a licensed producer in this state or another state having a law substantially similar to this article; or

(B) He is licensed in this state as a nonresident reinsurance intermediary.

(c) The commissioner may require a reinsurance intermediary manager subject to subsection (b) of this section to:

(i) File a bond, in an amount and from an insurer acceptable to the commissioner, for the protection of each reinsurer; and

(ii) Maintain an errors and omissions policy in an amount sufficient to protect each reinsurer.

(d) The commissioner may issue a reinsurance intermediary license to any person who has complied with the requirements of this article. Any reinsurance intermediary license issued to a firm or association shall authorize all the members of the firm or association and any designated employees to act as reinsurance intermediaries under the license. Any intermediary license issued to a corporation shall authorize all of the officers, and any designated employees and directors thereof to act as reinsurance intermediaries on behalf of the corporation. All members of the firm, association or corporation and employees designated to act as reinsurance intermediaries shall be named in the application and any supplements to the application.

(e) If the applicant for a reinsurance intermediary license is a nonresident, the applicant, as a condition precedent to receiving or holding a license, shall designate the

commissioner as agent for service of process in the manner, and with the same legal effect, provided for by this code for designation of service of process upon unauthorized insurers. The applicant also shall furnish the commissioner with the name and address of a resident of this state upon whom notices or orders of the commissioner or process affecting the nonresident reinsurance intermediary may be served. The licensee shall promptly notify the commissioner in writing of every change in its designated agent for service of process which shall not become effective until acknowledged by the commissioner.

(f) The commissioner shall not issue, continue or permit to exist any reinsurance intermediary license if the applicant, anyone named on the application, or any member, principal, officer or director of the applicant has:

(i) Had a reinsurance intermediary license revoked or suspended; or

(ii) Failed to comply with any prerequisite for the issuance of such license.

(g) Any person applying for or holding a reinsurance intermediary license shall:

(i) Have experience either as an agent, adjuster, managing general agent, broker, consultant or other special experience, education or training, all of sufficient content and duration reasonably necessary for competence in fulfilling the responsibilities of a reinsurance intermediary; and

(ii) Be competent, trustworthy, financially responsible and of good reputation.

(h) Licensed attorneys of this state when acting in their professional capacity as such shall be exempt from this section.

26-47-104. Required contract provisions for reinsurance intermediary brokers.

(a) Transactions between a reinsurance intermediary broker and the insurer it represents in such capacity shall only be entered into pursuant to a written authorization, specifying the responsibilities of each party. The authorization shall, at a minimum, provide that:

(i) The insurer may terminate the reinsurance intermediary broker's authority at any time;

(ii) The reinsurance intermediary broker shall render accounts to the insurer accurately detailing all material transactions, including information necessary to support all commissions, charges and other fees received by, or owing to, the reinsurance intermediary broker, and remit all funds due to the insurer within thirty (30) days of receipt;

(iii) All funds collected for the insurer's account shall be held by the reinsurance intermediary broker in a fiduciary capacity in a bank which is a qualified United States financial institution;

(iv) The reinsurance intermediary broker shall comply with W.S. 26-47-105;

(v) The reinsurance intermediary broker shall comply with the written standards established by the insurer for the cession or retrocession of all risks;

(vi) The reinsurance intermediary broker shall disclose to the insurer any relationship with any reinsurer to which business will be ceded or retroceded.

26-47-105. Books and records; reinsurance intermediary brokers.

(a) For at least ten (10) years after expiration of each contract of reinsurance transacted by the reinsurance intermediary broker, the reinsurance intermediary broker shall keep a complete record for each transaction showing:

(i) The type of contract, limits, underwriting restrictions, classes or risks and territory;

(ii) Period of coverage, including effective and expiration dates, cancellation provisions and notice required of cancellation;

(iii) Reporting and settlement requirements of balances;

(iv) Rates used to compute the reinsurance premium;

(v) Names and addresses of assuming reinsurers;

(vi) Rates of all reinsurance commissions, including the commissions on any retrocessions handled by the reinsurance intermediary broker;

(vii) Related correspondence and memoranda;

(viii) Proof of placement;

(ix) Details regarding retrocessions handled by the reinsurance intermediary broker including the identity of retrocessionaires and the percentage of each contract assumed or ceded;

(x) Financial records, including but not limited to, premium and loss accounts; and

(xi) When the reinsurance intermediary broker procures a reinsurance contract on behalf of a licensed ceding insurer:

(A) Directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk; or

(B) If placed through a representative of the assuming reinsurer, other than an employee, written evidence that the assuming reinsurer has delegated binding authority to the representative.

(b) The insurer shall have access and the right to copy and audit all accounts and records maintained by the reinsurance intermediary broker related to its business in a form usable by the insurer.

26-47-106. Duties of insurers utilizing the services of a reinsurance intermediary broker.

(a) An insurer shall not engage the services of any person to act as a reinsurance intermediary broker on its behalf unless the person is licensed as required by W.S. 26-47-103(a).

(b) An insurer shall not employ an individual who is employed by a reinsurance intermediary broker with which it transacts business, unless the reinsurance intermediary broker is under common control with the insurer and subject to the Insurance Holding Company System Regulatory Act.

(c) The insurer shall annually obtain a copy of statements of the financial condition of each reinsurance intermediary broker with which it transacts business.

26-47-107. Required contract provisions; reinsurance intermediary managers.

(a) Transactions between a reinsurance intermediary manager and the reinsurer it represents in such capacity shall only be entered into pursuant to a written contract, specifying the responsibilities of each party, which shall be approved by the reinsurer's board of directors. At least forty-five (45) days before a reinsurer assumes or cedes business through a reinsurance intermediary manager, a true copy of the contract shall be filed with the commissioner for approval pursuant to W.S. 26-15-110(b) and 26-15-111. The contract shall, at a minimum, provide that:

(i) The reinsurer may terminate the contract for cause upon written notice to the reinsurance intermediary manager. The reinsurer may immediately suspend the authority of the reinsurance intermediary manager to assume or cede business during the pendency of any dispute regarding the cause for termination;

(ii) The reinsurance intermediary manager shall render accounts to the reinsurer accurately detailing all material transactions, including information necessary to support all commissions, charges and other fees received by, or owing to, the reinsurance intermediary manager, and remit all funds due under the contract to the reinsurer on not less than a monthly basis;

(iii) All funds collected for the reinsurer's account shall be held by the reinsurance intermediary manager in a fiduciary capacity in a bank which is a qualified United States financial institution. The reinsurance intermediary manager shall retain no more than three (3) months estimated claims payments and allocated loss adjustment expenses. The reinsurance intermediary manager shall maintain a separate bank account for each reinsurer that it represents;

(iv) The reinsurance intermediary manager shall comply with W.S. 26-47-108;

(v) The contract shall not be assigned in whole or in part by the reinsurance intermediary manager;

(vi) The reinsurance intermediary manager shall comply with the written underwriting and rating standards established by the insurer for the acceptance, rejection or cession of all risks;

(vii) The rates, terms and purposes of commissions, charges and other fees which the reinsurance intermediary manager may levy against the reinsurer;

(viii) If the contract permits the reinsurance intermediary manager to settle claims on behalf of the reinsurer:

(A) All claims shall be reported to the reinsurer in a timely manner;

(B) A copy of the claim file shall be sent to the reinsurer at its request or as soon as it becomes known that the claim:

(I) Has the potential to exceed an amount determined by the commissioner or the limit set by the reinsurer whichever is less;

(II) Involves a coverage dispute;

(III) May exceed the reinsurance intermediary manager's claims settlement authority;

(IV) Is open for more than six (6) months; or

(V) Is closed by payment exceeding an amount set by the commissioner, or an amount set by the reinsurer, whichever is less.

(C) All claim files shall be the joint property of the reinsurer and reinsurance intermediary manager. Upon an order of liquidation of the reinsurer the files shall become the sole property of the reinsurer or its estate. The reinsurance intermediary manager shall have reasonable access to and the right to copy the files on a timely basis;

(D) Any settlement authority granted to the reinsurance intermediary manager may be terminated for cause upon the reinsurer's written notice to the reinsurance intermediary manager or upon the termination of the contract. The reinsurer may suspend the settlement authority during the pendency of the dispute regarding the cause of termination.

(ix) If the contract provides for a sharing of interim profits by the reinsurance intermediary manager, the interim profits shall not be paid until:

(A) The adequacy of reserves on remaining claims has been verified pursuant to W.S. 26-47-110(c);

(B) For insurance business other than casualty insurance business, one (1) year after the end of each underwriting period; and

(C) For casualty insurance business, five (5) years after the end of each underwriting period, or a later period set by the commissioner for specified lines of insurance.

(x) The reinsurance intermediary manager shall annually provide the reinsurer with a statement of its financial condition prepared by an independent certified accountant;

(xi) The reinsurer shall at least semiannually conduct an onsite review of the underwriting and claims processing operations of the reinsurance intermediary manager;

(xii) The reinsurance intermediary manager shall disclose to the reinsurer any relationship it has with any insurer prior to ceding or assuming any business with the insurer pursuant to the contract;

(xiii) Within the scope of its actual or apparent authority the acts of the reinsurance intermediary manager shall be deemed to be the acts of the reinsurer on whose behalf it is acting.

26-47-108. Books and records; reinsurance intermediary managers.

(a) For at least ten (10) years after expiration of each contract of reinsurance transacted by the reinsurance intermediary manager, the reinsurance intermediary manager shall keep a complete record for each transaction showing:

(i) The type of contract, limits, underwriting restrictions, classes or risks and territory;

(ii) Period of coverage, including effective and expiration dates, cancellation provisions and notice required of cancellation and disposition of outstanding reserves on covered risks;

(iii) Reporting and settlement requirements of balances;

(iv) Rates used to compute the reinsurance premium;

(v) Names and addresses of reinsurers;

(vi) Rates of all reinsurance commissions, including the commissions on any retrocessions handled by the reinsurance intermediary manager;

(vii) Related correspondence and memoranda;

(viii) Proof of placement;

(ix) Details regarding retrocessions handled by the reinsurance intermediary manager, as permitted by W.S. 26-47-110(d), including the identity of retrocessionaires and percentage of each contract assumed or ceded;

(x) Financial records, including but not limited to, premium and loss accounts; and

(xi) When the reinsurance intermediary manager places a reinsurance contract on behalf of a ceding insurer:

(A) Directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk; or

(B) If placed through a representative of the assuming reinsurer, other than an employee, written evidence that the reinsurer has delegated binding authority to the representative.

(b) The reinsurer shall have access and the right to copy all accounts and records maintained by the reinsurance

intermediary manager related to its business in a form usable by the reinsurer.

26-47-109. Prohibited acts.

(a) The reinsurance intermediary manager shall not:

(i) Cede retrocessions on behalf of the reinsurer;

(ii) Commit the reinsurer to participate in reinsurance syndicates;

(iii) Appoint any producer without assuring that the producer is lawfully licensed to transact the type of reinsurance for which he is appointed;

(iv) Without prior approval of the reinsurer, pay or commit the reinsurer to pay a claim, net of retrocessions, that exceeds the lesser of an amount specified by the reinsurer or one percent (1%) of the reinsurer's surplus as regards policyholders as of December 31 of the last complete calendar year;

(v) Collect any payment from a retrocessionaire or commit the reinsurer to any claim settlement with a retrocessionaire, without prior approval of the reinsurer. If prior approval is given, a report on the payment or the claim settlement shall be promptly forwarded to the reinsurer;

(vi) Jointly employ an individual who is employed by the reinsurer unless the reinsurance intermediary manager is under common control with the reinsurer subject to the Insurance Holding Company Regulatory System Act;

(vii) Appoint a subreinsurance intermediary manager.

26-47-110. Duties of reinsurers utilizing the services of a reinsurance intermediary manager.

(a) A reinsurer shall not engage the services of any person to act as a reinsurance intermediary manager on its behalf unless the person is licensed as required by W.S. 26-47-103(b).

(b) The reinsurer shall annually obtain a copy of statements of the financial condition of each reinsurance intermediary manager which the reinsurer has engaged prepared by

an independent certified accountant in a form acceptable to the commissioner.

(c) If a reinsurance intermediary manager establishes loss reserves, the reinsurer shall annually obtain the opinion of an independent actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the reinsurance intermediary manager. This opinion shall be in addition to any other required loss reserve certification.

(d) Binding authority for all retrocessional contracts or participation in reinsurance syndicates shall rest with an officer of the reinsurer who shall not be affiliated with the reinsurance intermediary manager.

(e) Within thirty (30) days of termination of a contract with a reinsurance intermediary manager, the reinsurer shall provide written notification of the termination to the commissioner.

(f) A reinsurer shall not appoint to its board of directors, any officer, director, employee, controlling shareholder or subproducer of its reinsurance intermediary manager. This subsection shall not apply to relationships governed by the Insurance Holding Company Regulatory System Act or, if applicable, the Broker Controlled Insurer Act.

26-47-111. Examination authority.

A reinsurance intermediary shall be subject to examination by the commissioner pursuant to chapter 2 of the Wyoming Insurance Code. The commissioner shall have access to all books, bank accounts and records of the reinsurance intermediary in a form usable to the commissioner.

26-47-112. Penalties and liabilities.

(a) A reinsurance intermediary, insurer or reinsurer found by the commissioner to be in violation of any provision of this article, after a hearing conducted in accordance with W.S. 26-2-125 shall:

(i) For each separate violation, pay a penalty in an amount not to exceed five thousand dollars ($5,000.00);

(ii) Be subject to revocation or suspension of its license; and

(iii) If a violation was committed by the reinsurance intermediary, the reinsurance intermediary shall make restitution to the insurer, reinsurer, rehabilitator or liquidator of the insurer or reinsurer for the net losses incurred by the insurer or reinsurer attributable to the violation.

(b) Nothing contained in this section shall affect the right of the commissioner to impose any other penalties provided in this code.

(c) Nothing contained in this article is intended to or shall in any manner limit or restrict the rights of policyholders, claimants, creditors or other third parties.

26-47-113. Fees; rules and regulations.

(a) The commissioner may impose a biennial fee not to exceed one hundred dollars ($100.00) upon any reinsurance intermediary subject to the provisions of this article. The fee shall be in addition to any other fees provided in this code.

(b) The commissioner may adopt reasonable rules and regulations for the implementation and administration of the provisions of this article.

CHAPTER 48 - RISK-BASED CAPITAL

ARTICLE 1 - RISK BASED CAPITAL FOR INSURERS

26-48-101. Definitions.

(a) As used in this article:

(i) "Adjusted RBC report" means an RBC report which has been adjusted by the commissioner in accordance with W.S. 26-48-102(d);

(ii) "Corrective order" means an order issued by the commissioner specifying corrective actions which the commissioner has determined are required;

(iii) "Domestic insurer" means any insurance company formed under the laws of Wyoming excluding title insurers,

health maintenance organizations and hospital or medical service insurers;

(iv) "Foreign insurer" means any insurance company which is licensed to do business in this state but is not domiciled in this state excluding title insurers, health maintenance organizations and hospital or medical service insurers;

(v) "NAIC" means the National Association of Insurance Commissioners;

(vi) "Negative trend" means with respect to a life or disability insurer a negative trend over a period of time, as determined in accordance with the "trend test calculation" included in the life RBC instructions;

(vii) "RBC" means risk-based capital;

(viii) "RBC instructions" means the RBC report including risk-based capital instructions adopted by the commissioner, and as may be amended by the commissioner;

(ix) "RBC level" means an insurer's company action level RBC, regulatory action level RBC, authorized control level RBC or mandatory control level RBC where:

(A) "Company action level RBC" means, with respect to any insurer, the product of two (2) and its authorized control level RBC;

(B) "Regulatory action level RBC" means the product of one and one-half (1 1/2) and its authorized control level RBC;

(C) "Authorized control level RBC" means the number determined under the risk-based capital formula in accordance with the RBC instructions. This number for life or disability insurers is equal to fifty percent (50%) of the sum of the business risk-based capital plus the square root of the sum of the asset risk-based capital plus the interest rate risk-based capital squared plus the insurance risk-based capital squared. This number for property and casualty insurers is equal to forty-five percent (45%) for 1995, fifty percent (50%) for 1996, and after, of the square root of the sum of the squares of loss reserve risk, premiums written risk, investment risk and

credit risk, plus total investments in affiliates, noncontrolled assets, guarantees for affiliates and contingent liabilities;

(D) "Mandatory control level RBC" means the product of seven tenths (.7) and the authorized control level RBC.

(x) "RBC plan" means a comprehensive financial plan containing the elements specified in W.S. 26-48-103(b). If the commissioner rejects the RBC plan, and it is revised by the insurer, with or without the commissioner's recommendation, the plan shall be called the "revised RBC plan";

(xi) "RBC report" means the report required in W.S. 26-48-102;

(xii) "Total adjusted capital" means the sum of:

(A) An insurer's statutory capital and surplus; and

(B) Such other items, if any, as the RBC instructions may provide.

(xiii) "Life or disability insurer" means any insurance company licensed in the lines of life, disability, or both, or a licensed property and casualty insurer writing only accident and health insurance, but shall not include health maintenance organizations or hospital or medical service insurers;

(xiv) "Property and casualty insurer" means any insurance company licensed in the lines of property, casualty, surety, marine and transportation, or any combination of these lines, but shall not include monoline mortgage guaranty insurers, financial guaranty insurers or title insurers.

26-48-102. Risk-based capital reports.

(a) Every domestic insurer shall, annually on or prior to March 1, prepare and submit to the commissioner a report of its RBC levels as of the end of the calendar year just ended, in a form and containing information as required by the RBC instructions. In addition, every domestic insurer shall file its RBC report:

(i) With the NAIC in accordance with the RBC instructions; and

(ii) With the insurance commissioner in any state in which the insurer is authorized to do business, if the insurance commissioner has notified the insurer of its request in writing, in which case the insurer shall file its RBC report not later than the later of:

(A) Fifteen (15) days from the receipt of notice to file its RBC report with that state; or

(B) The filing date specified in subsection (a) of this section.

(b) A life or disability insurer's RBC shall be determined in accordance with the formula set forth in the RBC instructions and this article. The formula shall take into account, and may adjust for the covariance between the following which are determined in each case by applying the factors in the manner set forth in the RBC instructions:

(i) The risk with respect to the insurer's assets;

(ii) The risk of adverse insurance experience with respect to the insurer's liabilities and obligations;

(iii) The interest rate risk with respect to the insurer's business; and

(iv) All other business risks and other relevant risks as set forth in the RBC instructions.

(c) A property and casualty insurer's RBC shall be determined in accordance with the formula set forth in the RBC instructions and this article. The formula shall take into account, and may adjust for the covariance between the following which are determined in each case by applying the factors in the manner set forth in the RBC instructions:

(i) Asset risk;

(ii) Credit risk;

(iii) Underwriting risk; and

(iv) All other business risks and such other relevant risks as are set forth in the RBC instructions.

(d) If a domestic insurer files an RBC report which in the judgment of the commissioner is inaccurate, the commissioner shall adjust the RBC report to correct the inaccuracy and shall notify the insurer of the adjustment. The notice shall contain a statement of the reason for the adjustment. A RBC report as so adjusted is referred to as an "adjusted RBC report."

26-48-103. Company action level event.

(a) "Company action level event" means any of the following events:

(i) The filing of an RBC report by an insurer which indicates any of the following:

(A) The insurer's total adjusted capital is greater than or equal to its regulatory action level RBC but less than its company action level RBC;

(B) If a life or disability insurer, the insurer has total adjusted capital which is greater than or equal to its company action level RBC but less than the product of authorized control level RBC and three (3), and has a negative trend; or

(C) If a property and casualty insurer, the insurer has total adjusted capital which is greater than or equal to its company action level RBC but less than three (3) times its authorized control level RBC and triggers the trend test in accordance with the trend test calculation included in the property and casualty RBC instructions.

(ii) The notification by the commissioner to the insurer of an adjusted RBC report that indicates the event in subparagraph (a)(i)(A) or (B) of this section, provided the insurer does not challenge the adjusted RBC report under W.S. 26-48-107; or

(iii) If the insurer challenges an adjusted RBC report that indicates the event in subparagraph (a)(i)(A) or (B) of this section, under W.S. 26-48-107, the notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(b) In the event of a company action level event, the insurer shall prepare and submit to the commissioner an RBC plan which shall:

(i) Identify the conditions in the insurer which contribute to the company action level event;

(ii) Contain proposals of corrective actions which the insurer intends to take and would be expected to result in the elimination of the company action level event;

(iii) Provide projections of the insurer's financial results in the current year and at least the four (4) succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, capital and surplus;

(iv) Identify the key assumptions impacting the insurer's projections and the sensitivity of the projections to the assumptions; and

(v) Identify the quality of, and problems associated with, the insurer's business, including but not limited to its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance in each case, if any.

(c) The RBC plan shall be submitted:

(i) Within forty-five (45) days of the company action level event; or

(ii) If the insurer challenges an adjusted RBC report under W.S. 26-48-107, within forty-five (45) days after notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(d) Within sixty (60) days after the submission by an insurer of an RBC plan to the commissioner, the commissioner shall notify the insurer whether the RBC plan shall be implemented or is, in the judgment of the commissioner, unsatisfactory. If the commissioner determines the RBC plan is unsatisfactory, the notification to the insurer shall set forth the reasons for the determination, and may set forth proposed revisions which will render the RBC plan satisfactory, in the judgment of the commissioner. Upon notification from the

commissioner, the insurer shall prepare a revised RBC plan, which may incorporate by reference any revisions proposed by the commissioner, and shall submit the revised RBC plan to the commissioner:

(i) Within forty-five (45) days after the notification from the commissioner; or

(ii) If the insurer challenges the notification from the commissioner under W.S. 26-48-107, within forty-five (45) days after a notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(e) In the event of a notification by the commissioner to an insurer that the insurer's RBC plan or revised RBC plan is unsatisfactory, the commissioner may at his discretion, subject to the insurer's right to a hearing under W.S. 26-48-107, specify in the notification that the notification constitutes a regulatory action level event.

(f) Every domestic insurer which files an RBC plan or revised RBC plan with the commissioner shall file a copy of the RBC plan or revised RBC plan with the insurance commissioner in any state in which the insurer is authorized to do business if:

(i) The state has an RBC provision substantially similar to W.S. 26-48-108(a); and

(ii) The insurance commissioner of that state has notified the insurer of its request for the filing in writing, in which case the insurer shall file a copy of the RBC plan or revised RBC plan in that state no later than the later of:

(A) Fifteen (15) days after the receipt of notice to file a copy of its RBC plan or revised RBC plan with the state; or

(B) The date on which the RBC plan or revised RBC plan is filed under subsections (c) and (d) of this section.

26-48-104. Regulatory action level event.

(a) "Regulatory action level event" means, with respect to any insurer, any of the following events:

(i) The filing of an RBC report by the insurer which indicates that the insurer's total adjusted capital is greater

than or equal to its authorized control level RBC but less than its regulatory action level RBC;

(ii) The notification by the commissioner to an insurer of an adjusted RBC report that indicates the event in paragraph (i) of this subsection, provided the insurer does not challenge the adjusted RBC report under W.S. 26-48-107;

(iii) If the insurer challenges an adjusted RBC report that indicates the event in paragraph (i) of this subsection, under W.S. 26-48-107, the notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge;

(iv) The failure of the insurer to file an RBC report annually by March 15, unless the insurer has provided an explanation for the failure which is satisfactory to the commissioner and has filed an RBC report by March 25;

(v) The failure of the insurer to submit an RBC plan to the commissioner within the time period set forth in W.S. 26-48-103(c);

(vi) Notification by the commissioner to the insurer that:

(A) The RBC plan or revised RBC plan submitted by the insurer is, in the judgment of the commissioner, unsatisfactory; and

(B) Such notification constitutes a regulatory action level event with respect to the insurer, provided the insurer has not challenged the determination under W.S. 26-48-107.

(vii) If the insurer challenges a determination by the commissioner under paragraph (vi) of this subsection pursuant to W.S. 26-48-107, the notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the challenge;

(viii) Notification by the commissioner to the insurer that the insurer has failed to adhere to its RBC plan or revised RBC plan, but only if the failure has a substantial adverse effect on the ability of the insurer to eliminate the company action level event in accordance with its RBC plan or revised RBC plan and the commissioner has so stated in the

notification, provided the insurer has not challenged the determination under W.S. 26-48-107; or

(ix) If the insurer challenges a determination by the commissioner under paragraph (viii) of this subsection pursuant to W.S. 26-48-107, the notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the challenge, unless the failure of the insurer to adhere to its RBC plan or revised RBC plan has no substantial adverse effect on the ability of the insurer to eliminate the regulatory action level event with respect to the insurer.

(b) In the event of a regulatory action level event the commissioner shall:

(i) Require the insurer to prepare and submit an RBC plan or, if applicable, a revised RBC plan;

(ii) Perform an examination or analysis as he deems necessary of the assets, liabilities and operations of the insurer including a review of its RBC plan or revised RBC plan; and

(iii) Subsequent to the examination or analysis, issue an order specifying the corrective actions he determines are required.

(c) In determining corrective actions, the commissioner may take into account factors deemed relevant with respect to the insurer based upon his examination or analysis of the assets, liabilities and operations of the insurer, including, but not limited to, the results of any sensitivity tests undertaken pursuant to the RBC instructions. The RBC plan or revised RBC plan shall be submitted:

(i) Within forty-five (45) days after the occurrence of the regulatory action level event;

(ii) If the insurer challenges an adjusted RBC report under W.S. 26-48-107, within forty-five (45) days after the notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge; or

(iii) If the insurer challenges a revised RBC plan under W.S. 26-48-107, within forty-five (45) days after notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(d) The commissioner may retain actuaries and investment experts and other consultants necessary in the judgment of the commissioner to review the insurer's RBC plan or revised RBC plan, examine or analyze the assets, liabilities and operations of the insurer and formulate the corrective order with respect to the insurer. The fees, costs and expenses relating to consultants shall be borne by the affected insurer or other party as directed by the commissioner.

26-48-105. Authorized control level event.

(a) "Authorized control level event" means any of the following events:

(i) The filing of an RBC report by the insurer which indicates that the insurer's total adjusted capital is greater than or equal to its mandatory control level RBC but less than its authorized control level RBC;

(ii) The notification by the commissioner to the insurer of an adjusted RBC report that indicates the event in paragraph (i) of this subsection, provided the insurer does not challenge the adjusted RBC report under W.S. 26-48-107;

(iii) If the insurer challenges an adjusted RBC report that indicates the event in paragraph (i) of this subsection, under W.S. 26-48-107, notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge;

(iv) The failure of the insurer to respond, in a manner satisfactory to the commissioner, to a corrective order, provided the insurer has not challenged the corrective order under W.S. 26-48-107; or

(v) If the insurer has challenged a corrective order under W.S. 26-48-107 and the commissioner has, after a hearing, rejected the challenge or modified the corrective order, the failure of the insurer to respond, in a manner satisfactory to the commissioner, to the corrective order subsequent to the rejection or modification by the commissioner.

(b) In the event of an authorized control level event with respect to an insurer, the commissioner shall:

(i) Take actions required under W.S. 26-48-104 regarding an insurer with respect to which a regulatory action level event has occurred; or

(ii) If the commissioner deems it to be in the best interests of the policyholders and creditors of the insurer and of the public, take actions necessary to cause the insurer to be placed under regulatory control under chapter 28 of this code. In the event the commissioner determines to take such action, the authorized control level event shall be deemed sufficient grounds for the commissioner to proceed under chapter 28, and the commissioner shall have the rights, powers and duties with respect to the insurer as are set forth in that chapter.

26-48-106. Mandatory control level event.

(a) "Mandatory control level event" means any of the following events:

(i) The filing of an RBC report which indicates that the insurer's total adjusted capital is less than its mandatory control level RBC;

(ii) Notification by the commissioner to the insurer of an adjusted RBC report that indicates the event in paragraph (i) of this subsection, provided the insurer does not challenge the adjusted RBC report under W.S. 26-48-107; or

(iii) If the insurer challenges an adjusted RBC report that indicates the event in paragraph (i) of this subsection under W.S. 26-48-107, notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(b) In the event of a mandatory control level event:

(i) With respect to a life or disability insurer, the commissioner shall take actions necessary to cause the insurer to be placed under regulatory control under chapter 28 of this code. In that event, the mandatory control level event shall be deemed sufficient grounds for the commissioner to take action under chapter 28, and the commissioner shall have the rights, powers and duties with respect to the insurer as are set forth in that chapter. The commissioner may forego action under this subsection for up to ninety (90) days after the mandatory control level event if he finds there is a reasonable

expectation that the mandatory control level event may be eliminated within the ninety (90) day period;

(ii) With respect to a property and casualty insurer, the commissioner shall take actions necessary to cause the insurer to be placed under regulatory control under chapter 28 of this code, or, in the case of an insurer which is writing no business and which is running-off its existing business, may allow the insurer to continue its run-off under the supervision of the commissioner. In either event, the mandatory control level event shall be deemed sufficient grounds for the commissioner to take action under chapter 28 and the commissioner shall have the rights, powers and duties with respect to the insurer as are set forth in that chapter. The commissioner may forego action under this subsection for up to ninety (90) days after the mandatory control level event if he finds there is a reasonable expectation that the mandatory control level event may be eliminated within the ninety (90) day period.

26-48-107. Hearings.

(a) An insurer shall have the right to a departmental hearing, on a record, at which the insurer may challenge any of the following determinations or actions by the commissioner:

(i) Notification to an insurer by the commissioner of an adjusted RBC report;

(ii) Notification to an insurer by the commissioner that:

(A) The insurer's RBC plan or revised RBC plan is unsatisfactory; and

(B) The notification constitutes a regulatory action level event with respect to the insurer.

(iii) Notification to any insurer by the commissioner that the insurer has failed to adhere to its RBC plan or revised RBC plan and that the failure has a substantial adverse effect on the ability of the insurer to eliminate the company action level event with respect to the insurer in accordance with its RBC plan or revised RBC plan; or

(iv) Notification to an insurer by the commissioner of a corrective order with respect to the insurer.

(b) An insurer seeking a hearing under this section shall notify the commissioner of its request for a hearing within five (5) days after the notification by the commissioner under subsection (a) of this section. Upon receipt of the insurer's request for a hearing, the commissioner shall set a date for the hearing, which shall be no less than ten (10) nor more than thirty (30) days after the date of the insurer's request.

26-48-108. Confidentiality and prohibition on announcements.

(a) To the extent the information therein is not required to be set forth in a publicly available annual statement schedule, all RBC reports and RBC plans, including the results or report of any examination or analysis of an insurer performed pursuant to this article, and any corrective order issued by the commissioner pursuant to examination or analysis, with respect to any domestic insurer or foreign insurer which are filed with the commissioner constitute information that might be damaging to the insurer if made available to its competitors, and shall be kept confidential by the commissioner. This information shall not be made public, other than by the commissioner and then only for the purpose of enforcement actions taken by the commissioner pursuant to this article or any other provision of the insurance laws of this state. W.S. 16-4-201 through 16-4-205 shall not apply to the documents or information described in this section.

(b) Except as otherwise required under the provisions of this article, making, publishing, disseminating, circulating or placing before the public, an advertisement, announcement or statement containing a representation or statement with regard to the RBC levels of any insurer, or of any component derived in the calculation, by any insurer, agent, broker or other person engaged in any manner in the insurance business is prohibited. If any materially false statement with respect to the comparison regarding an insurer's total adjusted capital to its RBC levels, or any of them, or an inappropriate comparison of any other amount to the insurers' RBC levels is published in any written publication and the insurer is able to demonstrate to the commissioner with substantial proof of the falsity or inappropriateness of the statement, the insurer may publish an announcement in a written publication for the sole purpose of rebutting the statement.

26-48-109. Supplemental provisions; rulemaking authority; exceptions; limitations.

(a) The provisions of this article are supplemental to any other provisions of the laws of this state, and shall not preclude or limit any other powers or duties of the commissioner under those laws, including, but not limited to, chapter 28 of this code, W.S. 26-3-115 and 26-3-116.

(b) The commissioner may adopt reasonable rules and regulations necessary for the implementation of this article.

(c) The commissioner may exempt from the application of this chapter any domestic property and casualty insurer which:

(i) Writes direct business only in Wyoming;

(ii) Writes direct annual premiums of two million dollars ($2,000,000.00) or less; and

(iii) Assumes no reinsurance in excess of five percent (5%) of direct premium written.

(d) The RBC instructions, RBC reports, adjusted RBC reports, RBC plans and revised RBC plans may be used solely by the commissioner in monitoring the solvency of insurers and determining the need for possible corrective action with respect to insurers and shall not be used by the commissioner for rate making nor considered or introduced as evidence in any rate proceeding nor used by the commissioner to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance which an insurer or any affiliate is authorized to write.

26-48-110. Foreign Insurers.

(a) Any foreign insurer not subject to a substantially similar RBC law in its domicile, shall submit to the commissioner an RBC report on or before March 15, for the preceding calendar year. Any other foreign insurer shall, upon the written request of the commissioner, submit to the commissioner an RBC report as of the end of the calendar year just ended by the later of:

(i) The date an RBC report would be required to be filed by a domestic insurer under this article; or

(ii) Fifteen (15) days after the request is received by the foreign insurer.

(b) Any foreign insurer shall, at the written request of the commissioner, within fifteen (15) business days submit to the commissioner a copy of any RBC plan that is filed with the insurance commissioner of any other state.

(c) Pursuant to regulations adopted by the commissioner, in the event of a company action level event, regulatory action level event or authorized control level event, the commissioner may require the foreign insurer to file an RBC plan with the commissioner. In such event, the failure of the foreign insurer to file an RBC plan with the commissioner shall be grounds to order the insurer to cease and desist from writing new insurance business in this state.

(d) In the event of a mandatory control level event with respect to any foreign insurer, if no domiciliary receiver has been appointed with respect to the foreign insurer under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign insurer, the commissioner may make application for the appointment of a receiver to the district court of Laramie county as permitted under chapter 28 of this code. The occurrence of the mandatory control level event shall be considered adequate grounds for the application.

26-48-111. Notices.

All notices by the commissioner to an insurer which may result in regulatory action under this article shall be effective upon mailing if transmitted by registered or certified mail, or in the case of any other transmission shall be effective upon the insurer's receipt of the notice.

26-48-112. Phase-in provision.

(a) For RBC reports required to be filed by life or disability insurers with respect to 1994, the following requirements shall apply in lieu of the provisions of W.S. 26-48-103 through 26-48-106:

(i) In the event of a company action level event with respect to a domestic insurer, the commissioner shall take no regulatory action under this chapter;

(ii) In the event of a regulatory action level event under W.S. 26-48-104(a)(i) through (iii) the commissioner shall take the actions required under W.S. 26-48-103;

(iii) In the event of a regulatory action level event under W.S. 26-48-104(a)(iv) through (ix) or an authorized control level event, the commissioner shall take the actions required under W.S. 26-48-104 with respect to the insurer;

(iv) In the event of a mandatory control level event, the commissioner shall take the actions required under W.S. 26-48-105 with respect to the insurer.

(b) For RBC reports required to be filed by property and casualty insurers with respect to 1995, the following requirements shall apply in lieu of the provisions of W.S. 26-48-103 through 26-48-106:

(i) In the event of a company action level event with respect to a domestic insurer, the commissioner shall take no regulatory action under this chapter;

(ii) In the event of a regulatory action level event under W.S. 26-48-104(a)(i) through (iii) the commissioner shall take the actions required under W.S. 26-48-103;

(iii) In the event of a regulatory action level event under W.S. 26-48-104(a)(iv) through (ix) or an authorized control level event, the commissioner shall take the actions required under W.S. 26-48-104 with respect to the insurer;

(iv) In the event of a mandatory control level event with respect to an insurer, the commissioner shall take the actions required under W.S. 26-48-105 with respect to the insurer.

(c) W.S. 26-48-110(a) shall not be effective for any foreign insurer until July 1, 1996, unless the commissioner requests in writing that the foreign insurer submit an RBC report.

ARTICLE 2 - RISK-BASED CAPITAL FOR HEALTH ORGANIZATIONS

26-48-201. Definitions.

(a) As used in this article:

(i) "Adjusted RBC report" means an RBC report which has been adjusted by the commissioner in accordance with W.S. 26-48-202(c);

(ii) "Corrective order" means an order issued by the commissioner specifying corrective actions which the commissioner has determined are required;

(iii) "Domestic health organization" means a health organization domiciled in this state;

(iv) "Foreign health organization" means a health organization that is licensed to do business in this state but is not domiciled in this state;

(v) "Health organization" means a health maintenance organization, limited health service organization, dental or vision plan, hospital, medical and dental indemnity or service corporation or other managed care organization licensed under chapter 3 or chapter 34 of this title. This definition does not include an organization that is licensed as either a life and health insurer or a property and casualty insurer as defined in W.S. 26-48-101(a)(xiii) and (xiv) and that is otherwise subject to either the life or property and casualty risk based capital requirements of W.S. 26-48-101 through 26-48-112;

(vi) "NAIC" means the National Association of Insurance Commissioners;

(vii) "RBC" means risk-based capital;

(viii) "RBC instructions" means the RBC report including risk-based capital instructions adopted by the commissioner, and as may be amended by the commissioner;

(ix) "RBC level" means a health organization's company action level RBC, regulatory action level RBC, authorized control level RBC or mandatory control level RBC where:

(A) "Company action level RBC" means, with respect to any health organization, the product of two (2) and its authorized control level RBC;

(B) "Regulatory action level RBC" means the product of one and one-half (1.5) and its authorized control level RBC;

(C) "Authorized control level RBC" means the number determined under the risk-based capital formula in accordance with the RBC instructions;

(D) "Mandatory control level RBC" means the product of seven-tenths (.7) and the authorized control level RBC.

(x) "RBC plan" means a comprehensive financial plan containing the elements specified in W.S. 26-48-203(b). If the commissioner rejects the RBC plan, and it is revised by the health organization, with or without the commissioner's recommendation, the plan shall be called the "revised RBC plan";

(xi) "RBC report" means the report required in W.S. 26-48-202;

(xii) "Total adjusted capital" means the sum of:

(A) A health organization's statutory capital and surplus as determined in accordance with the statutory accounting applicable to the annual financial statements required to be filed under W.S. 26-3-123 or 26-34-110; and

(B) Such other items, if any, as the RBC instructions may provide.

26-48-202. Risk-based capital reports.

(a) A domestic health organization shall, annually on or prior to March 1, prepare and submit to the commissioner a report of its RBC levels as of the end of the calendar year just ended, in a form and containing information as required by the RBC instructions. In addition, every domestic health organization shall file its RBC report:

(i) With the NAIC in accordance with the RBC instructions; and

(ii) With the insurance commissioner in any state in which the health organization is authorized to do business, if the insurance commissioner has notified the health organization of its request in writing, in which case the health organization shall file its RBC report not later than the later of:

(A) Fifteen (15) days from the receipt of notice to file its RBC report with that state; or

(B) March 1.

(b) A health organization's RBC shall be determined in accordance with the formula set forth in the RBC instructions and this article. The formula shall take the following into account, and may adjust for the covariance between the following which are determined in each case by applying the factors in the manner set forth in the RBC instructions:

(i) Asset risk;

(ii) Credit risk;

(iii) Underwriting risk; and

(iv) All other business risks and other relevant risks as are set forth in the RBC instructions.

(c) If a domestic health organization files an RBC report which in the judgment of the commissioner is inaccurate, the commissioner shall adjust the RBC report to correct the inaccuracy and shall notify the health organization of the adjustment. The notice shall contain a statement of the reasons for the adjustment. An RBC report as so adjusted is referred to as an "adjusted RBC report".

(d) An excess of capital over the amount produced by the risk-based capital requirements contained in this article and the formulas, schedules and instructions referenced in this article is desirable in the business of health insurance. Accordingly, health organizations should seek to maintain capital above the RBC levels required by this article. Additional capital is used and useful in the insurance business and helps to secure a health organization against various risks inherent in, or affecting, the business of insurance and not accounted for or only partially measured by the risk-based capital requirements contained in this article.

26-48-203. Company action level event.

(a) "Company action level event" means any of the following events:

(i) The filing of an RBC report by a health organization that indicates that the health organization's total adjusted capital is greater than or equal to its regulatory action level RBC but less than its company action level RBC;

(ii) If a health organization has total adjusted capital which is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and three (3) and triggers the trend test determined in accordance with the trend test calculation included in the health RBC instructions;

(iii) Notification by the commissioner to the health organization of an adjusted RBC report that indicates an event in paragraph (i) or (ii) of this subsection, provided the health organization does not challenge the adjusted RBC report under W.S. 26-48-207; or

(iv) If a health organization challenges an adjusted RBC report that indicates the event in paragraph (i) or (ii) of this subsection under W.S. 26-48-207, the notification by the commissioner to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge.

(b) In the event of a company action level event, the health organization shall prepare and submit to the commissioner an RBC plan which shall:

(i) Identify the conditions that contribute to the company action level event;

(ii) Contain proposals of corrective actions that the health organization intends to take and that would be expected to result in the elimination of the company action level event;

(iii) Provide projections of the health organization's financial results in the current year and at least the two (2) succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory balance sheets, operating income, net income, capital and surplus and RBC levels. The projections for both new and renewal business may include separate projections for each major line of business and separately identify each significant income, expense and benefit component;

(iv) Identify the key assumptions impacting the health organization's projections and the sensitivity of the projections to the assumptions; and

(v) Identify the quality of, and problems associated with, the health organization's business, including but not limited to its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance, if any, in each case.

(c) The RBC plan shall be submitted:

(i) Within forty-five (45) days of the company action level event; or

(ii) If the health organization challenges an adjusted RBC report under W.S. 26-48-207, within forty-five (45) days after notification to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge.

(d) Within sixty (60) days after the submission by a health organization of an RBC plan to the commissioner, the commissioner shall notify the health organization whether the RBC plan shall be implemented or is, in the judgment of the commissioner, unsatisfactory. If the commissioner determines the RBC plan is unsatisfactory, the notification to the health organization shall set forth the reasons for the determination, and may set forth proposed revisions which will render the RBC plan satisfactory, in the judgment of the commissioner. Upon notification from the commissioner, the health organization shall prepare a revised RBC plan, which may incorporate by reference any revisions proposed by the commissioner, and shall submit the revised RBC plan to the commissioner:

(i) Within forty-five (45) days after the notification from the commissioner; or

(ii) If the health organization challenges the notification from the commissioner under W.S. 26-48-207, within forty-five (45) days after a notification to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge.

(e) In the event of a notification by the commissioner to a health organization that the health organization's RBC plan or revised RBC plan is unsatisfactory, the commissioner may,

subject to the health organization's right to a hearing under W.S. 26-48-207, specify in the notification that the notification constitutes a regulatory action level event.

(f) Every domestic health organization that files an RBC plan or revised RBC plan with the commissioner shall file a copy of the RBC plan or revised RBC plan with the insurance commissioner in any state in which the health organization is authorized to do business if:

(i) The state has an RBC provision substantially similar to W.S. 26-48-208(a); and

(ii) The insurance commissioner of that state has notified the health organization of its request for the filing in writing, in which case the health organization shall file a copy of the RBC plan or revised RBC plan in that state no later than the later of:

(A) Fifteen (15) days after the receipt of notice to file a copy of its RBC plan or revised RBC plan with the state; or

(B) The date on which the RBC plan or revised RBC plan is filed under subsections (c) and (d) of this section.

26-48-204. Regulatory action level event.

(a) "Regulatory action level event" means, with respect to a health organization, any of the following events:

(i) The filing of an RBC report by the health organization that indicates that the health organization's total adjusted capital is greater than or equal to its authorized control level RBC but less than its regulatory action level RBC;

(ii) Notification by the commissioner to a health organization of an adjusted RBC report that indicates the event in paragraph (i) of this subsection, provided the health organization does not challenge the adjusted RBC report under W.S. 26-48-207;

(iii) If the health organization challenges an adjusted RBC report that indicates the event in paragraph (i) of this subsection under W.S. 26-48-207, the notification by the commissioner to the health organization that the commissioner

has, after a hearing, rejected the health organization's challenge;

(iv) The failure of the health organization to file an RBC report annually by March 1, unless the health organization has provided an explanation for the failure that is satisfactory to the commissioner and has cured the failure within ten (10) days after the filing date;

(v) The failure of the health organization to submit an RBC plan to the commissioner within the time period set forth in W.S. 26-48-203(c);

(vi) Notification by the commissioner to the health organization that:

(A) The RBC plan or revised RBC plan submitted by the health organization is, in the judgment of the commissioner, unsatisfactory; and

(B) Such notification constitutes a regulatory action level event with respect to the health organization, provided the health organization has not challenged the determination under W.S. 26-48-207.

(vii) If the health organization challenges a determination by the commissioner under paragraph (vi) of this subsection under W.S. 26-48-207, the notification by the commissioner to the health organization that the commissioner has, after a hearing, rejected the challenge;

(viii) Notification by the commissioner to the health organization that the health organization has failed to adhere to its RBC plan or revised RBC plan, but only if the failure has a substantial adverse effect on the ability of the health organization to eliminate the company action level event in accordance with its RBC plan or revised RBC plan and the commissioner has so stated in the notification, provided the health organization has not challenged the determination under W.S. 26-48-207; or

(ix) If the health organization challenges a determination by the commissioner under paragraph (viii) of this subsection under W.S. 26-48-207, the notification by the commissioner to the health organization that the commissioner has, after a hearing, rejected the challenge.

(b) In the event of a regulatory action level event the commissioner shall:

(i) Require the health organization to prepare and submit an RBC plan or, if applicable, a revised RBC plan;

(ii) Perform an examination or analysis as he deems necessary of the assets, liabilities and operations of the health organization including a review of its RBC plan or revised RBC plan; and

(iii) Subsequent to the examination or analysis, issue an order specifying such corrective actions as he shall determine are required.

(c) In determining corrective actions, the commissioner may take into account factors he deems relevant with respect to the health organization based upon his examination or analysis of the assets, liabilities and operations of the health organization, including, but not limited to, the results of any sensitivity tests undertaken pursuant to the RBC instructions. The RBC plan or revised RBC plan shall be submitted:

(i) Within forty-five (45) days after the occurrence of the regulatory action level event;

(ii) If the health organization challenges an adjusted RBC report under W.S. 26-48-207 and the challenge is not frivolous in the judgment of the commissioner, within forty-five (45) days after the notification to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge; or

(iii) If the health organization challenges a revised RBC plan under W.S. 26-48-207 and the challenge is not frivolous in the judgment of the commissioner, within forty-five (45) days after the notification to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge.

(d) The commissioner may retain actuaries and investment experts and other consultants necessary in the judgment of the commissioner to review the health organization's RBC plan or revised RBC plan, examine or analyze the assets, liabilities and operations of the health organization and formulate the corrective order with respect to the health organization. The fees, costs and expenses relating to consultants shall be borne

by the affected health organization or other party as directed by the commissioner.

26-48-205. Authorized control level event.

(a) "Authorized control level event" means any of the following events:

(i) The filing of an RBC report by the health organization that indicates that the health organization's total adjusted capital is greater than or equal to its mandatory control level RBC but less than its authorized control level RBC;

(ii) The notification by the commissioner to the health organization of an adjusted RBC report that indicates the event in paragraph (i) of this subsection, provided the health organization does not challenge the adjusted RBC report under W.S. 26-48-207;

(iii) If the health organization challenges an adjusted RBC report that indicates the event in paragraph (i) of this subsection under W.S. 26-48-207, notification by the commissioner to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge;

(iv) The failure of the health organization to respond, in a manner satisfactory to the commissioner, to a corrective order, provided the health organization has not challenged the corrective order under W.S. 26-48-207; or

(v) If the health organization has challenged a corrective order under W.S. 26-48-207 and the commissioner has, after a hearing, rejected the challenge or modified the corrective order, the failure of the health organization to respond, in a manner satisfactory to the commissioner, to the corrective order subsequent to rejection or modification by the commissioner.

(b) In the event of an authorized control level event with respect to a health organization, the commissioner shall:

(i) Take such actions as are required under W.S. 26-48-204 regarding a health organization with respect to which a regulatory action level event has occurred; or

(ii) If the commissioner deems it to be in the best interests of the policyholders and creditors of the health organization and of the public, take any actions as are necessary to cause the health organization to be placed under regulatory control under chapter 28 of this code. In the event the commissioner takes such actions, the authorized control level event shall be deemed sufficient grounds for the commissioner to take action under chapter 28, and the commissioner shall have the rights, powers and duties with respect to the health organization as are set forth in chapter 28. In the event the commissioner takes actions under this paragraph pursuant to an adjusted RBC report, the health organization shall be entitled to such protections as are afforded to health organizations under the provisions of chapter 28 pertaining to summary proceedings.

26-48-206. Mandatory control level event.

(a) "Mandatory control level event" means any of the following events:

(i) The filing of an RBC report which indicates that the health organization's total adjusted capital is less than its mandatory control level RBC;

(ii) Notification by the commissioner to the health organization of an adjusted RBC report that indicates the event in paragraph (i) of this subsection, provided the health organization does not challenge the adjusted RBC report under W.S. 26-48-207; or

(iii) If the health organization challenges an adjusted RBC report that indicates the event in paragraph (i) of this subsection under W.S. 26-48-207, notification by the commissioner to the health organization that the commissioner has, after a hearing, rejected the health organization's challenge.

(b) In the event of a mandatory control level event, the commissioner shall take such actions as are necessary to place the health organization under regulatory control under chapter 28 of this code. In that event, the mandatory control level event shall be deemed sufficient grounds for the commissioner to take action under chapter 28, and the commissioner shall have the rights, powers and duties with respect to the health organization as are set forth in chapter 28. If the commissioner takes actions pursuant to an adjusted RBC report,

the health organization shall be entitled to the protections of chapter 28 pertaining to summary proceedings. Notwithstanding any of the foregoing, the commissioner may forego action for up to ninety (90) days after the mandatory control level event if the commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the ninety (90) day period.

26-48-207. Hearings.

(a) A health organization shall have the right to an administrative hearing, on a record, at which the health organization may challenge any of the following determinations or actions by the commissioner:

(i) Notification to a health organization by the commissioner of an adjusted RBC report;

(ii) Notification to a health organization by the commissioner that:

(A) The health organization's RBC plan or revised RBC plan is unsatisfactory; and

(B) The notification constitutes a regulatory action level event with respect to the health organization.

(iii) Notification to any health organization by the commissioner that the health organization has failed to adhere to its RBC plan or revised RBC plan and that the failure has a substantial adverse effect on the ability of the health organization to eliminate the company action level event with respect to the health organization in accordance with its RBC plan or revised RBC plan; or

(iv) Notification to a health organization by the commissioner of a corrective order with respect to the health organization.

(b) A health organization seeking a hearing under this section shall notify the commissioner of its request for a hearing within five (5) days after the notification by the commissioner under subsection (a) of this section. Upon receipt of the health organization's request for a hearing, the commissioner shall set a date for the hearing, which shall be no less than ten (10) nor more than thirty (30) days after the date of receipt of the health organization's request.

26-48-208. Confidentiality; prohibition on announcements; prohibition on use in ratemaking.

(a) All RBC reports, to the extent the information is not required to be set forth in a publicly available annual statement schedule, and RBC plans, including the results or report of any examination or analysis of a health organization performed pursuant to this article and any corrective order issued by the commissioner pursuant to examination or analysis, with respect to a domestic health organization or foreign health organization that are in the possession or control of the department of insurance shall be confidential by law and privileged, shall not be subject to inspection under W.S. 16-4-201 through 16-4-205, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties.

(b) Neither the commissioner nor any person who received documents, materials or other information while acting under the authority of the commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials or information subject to subsection (a) of this section.

(c) In order to assist in the performance of the commissioner's duties, the commissioner:

(i) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to subsection (a) of this section, with other state, federal and international regulatory agencies, with the NAIC and its affiliates and subsidiaries and with state, federal and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material or other information;

(ii) May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the NAIC and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or

information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(iii) May enter into agreements governing sharing and use of information consistent with this subsection.

(d) No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in paragraph (c)(iii) of this section.

(e) The comparison of a health organization's total adjusted capital to any of its RBC levels is a regulatory tool which may indicate the need for corrective action with respect to the health organization and is not intended as a means to rank health organizations generally. Therefore, except as otherwise required under the provisions of this article, the 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 a radio or television station, or in any other way, an advertisement, announcement or statement containing an assertion, representation or statement with regard to the RBC levels of any health organization, or of any component derived in the calculation, by any health organization, agent, broker or other person engaged in any manner in the insurance business would be misleading and is therefore prohibited, provided, however, that if any materially false statement with respect to the comparison regarding a health organization's total adjusted capital to its RBC levels or an inappropriate comparison of any other amount to the health organizations' RBC levels is published in any written publication and the health organization is able to demonstrate to the commissioner with substantial proof the falsity of the statement, or the inappropriateness, as the case may be, then the health organization may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

(f) RBC instructions, RBC reports, adjusted RBC reports, RBC plans and revised RBC plans shall not be used by the commissioner for ratemaking nor considered or introduced as evidence in any rate proceeding nor used by the commissioner to calculate or derive any elements of an appropriate premium level

or rate of return for any line of insurance that a health organization or any affiliate is authorized to write.

26-48-209. Supplemental provisions; rules; exemptions.

(a) The provisions of this article are supplemental to any other provisions of the laws of this state, and shall not preclude or limit any other powers or duties of the commissioner under such laws, including, but not limited to, W.S. 26-3-115, 26-3-116, 26-28-101 through 26-28-131, 26-34-121 and 26-34-123.

(b) The commissioner may adopt reasonable rules necessary for the implementation of this article.

(c) The commissioner may exempt from the application of this article a domestic health organization that:

(i) Writes direct business only in this state;

(ii) Assumes no reinsurance in excess of five percent (5%) of direct premium written, and:

(A) Writes direct annual premiums for comprehensive medical business of two million dollars ($2,000,000.00) or less; or

(B) Is a limited health service organization that covers less than two thousand (2,000) lives.

26-48-210. Foreign health organizations.

(a) A foreign health organization shall, upon the written request of the commissioner, submit to the commissioner an RBC report as of the end of the calendar year just ended by the later of:

(i) The date an RBC report would be required to be filed by a domestic health organization under this article; or

(ii) Fifteen (15) days after the request is received by the foreign health organization.

(b) A foreign health organization shall, at the written request of the commissioner, promptly submit to the commissioner a copy of any RBC plan that is filed with the insurance commissioner of any other state.

(c) In the event of a company action level event, regulatory action level event or authorized control level event with respect to a foreign health organization as determined under the RBC statute applicable in the state of domicile of the health organization, or, if no RBC statute is in force in that state, under the provisions of this article, if the insurance commissioner of the state of domicile of the foreign health organization fails to require the foreign health organization to file an RBC plan in the manner specified under that state's RBC statute, or, if no RBC statute is in force in that state, under W.S. 26-48-203, the commissioner may require the foreign health organization to file an RBC plan with the commissioner. In such event, the failure of the foreign health organization to file an RBC plan with the commissioner shall be grounds to order the health organization to cease and desist from writing new insurance business in this state.

(d) In the event of a mandatory control level event with respect to a foreign health organization, if no domiciliary receiver has been appointed with respect to the foreign health organization under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign health organization, the commissioner may make application to the district court of Laramie county as permitted under chapter 28 of this code. The occurrence of the mandatory control level event shall be considered adequate grounds for the application.

26-48-211. Immunity.

There shall be no liability on the part of, and no cause of action shall arise against, the commissioner or the insurance department or its employees or agents for any action taken by them in the performance of their powers and duties under this article.

26-48-212. Notices.

All notices by the commissioner to a health organization that may result in regulatory action under this article shall be effective upon dispatch if transmitted by registered or certified mail, or in the case of any other transmission shall be effective upon the health organization's receipt of notice.

CHAPTER 49 - SERVICE CONTRACTS

26-49-101. Scope and purposes.

(a) The purpose of this article is to create a legal framework within which service contracts may be sold in this state.

(b) The following are exempt from W.S. 26-49-103 through 26-49-111:

(i) Warranties;

(ii) Maintenance agreements;

(iii) Warranties, service contracts and maintenance agreements offered by public utilities on their transmission devices to the extent they are regulated by public service commission; and

(iv) Service contracts sold or offered for sale to persons other than consumers.

(c) The types of agreements referred to in subsection (b) of this section do not have to comply with any provision of the insurance law of this state.

(d) This article does not apply to:

(i) Mechanical breakdown insurers licensed pursuant to chapter 37 of this code;

(ii) To mechanical breakdown insurance organizations who maintain a license pursuant to W.S. 26-37-106;

(iii) To motor club services regulated pursuant to the Motor Club Services Act;

(iv) Theft protection programs or their accompanying warranties except that theft protection programs and their accompanying warranties shall be subject to the enforcement provisions of W.S. 26-49-110.

26-49-102. Definitions.

(a) As used in this article:

(i) "Administrator" means the person who is responsible for the administration of the service contracts or the service contracts plans or who is responsible for any filings required by this article;

(ii) "Consumer" means a natural person who buys other than for purposes of resale any tangible personal property that is distributed in commerce and that is normally used for personal, family or household purposes and not for business or research purposes;

(iii) "Maintenance agreement" means a contract of limited duration that provides for scheduled maintenance only;

(iv) "Nonoriginal manufacturer's parts" means replacement parts not made for or by the original manufacturer of the property, commonly referred to as "after market parts";

(v) "Premium" means the consideration paid to an insurer for a reimbursement insurance policy;

(vi) "Provider" means a person who is contractually obligated to the service contract holder under the terms of the service contract;

(vii) "Provider fee" means the consideration paid for a service contract;

(viii) "Reimbursement insurance policy" means a policy of insurance that is issued to a provider to provide reimbursement to the provider or to pay on behalf of the provider all covered contractual obligations incurred by the provider under the terms of the insured service contracts issued or sold by the provider;

(ix) "Service contract" means a contract or agreement for a separately stated consideration for a specific duration to perform the repair, replacement or maintenance of property or indemnification for repair, replacement or maintenance, for the operational or structural failure due to a defect in materials or workmanship or normal wear and tear, with or without additional provision for incidental payment or indemnity under limited circumstances, including, but not limited to, towing, rental and emergency road service. Service contracts may provide for the repair, replacement or maintenance of property for damage resulting from power surges and accidental damage from handling. "Service contract" also includes a contract or agreement for one (1) or more of the following:

(A) The removal of dents, dings or creases that can be repaired using the process of paintless dent removal

without affecting the existing paint finish and without replacing vehicle body panels or sanding, bonding or painting;

(B) The repair or replacement of tires or wheels damaged as a result of coming into contact with ordinary road hazards. A contract or agreement meeting the definition set forth in this subparagraph in which the party obligated to perform is either a tire or wheel manufacturer or a motor vehicle manufacturer is exempt from the requirements of this chapter;

(C) The repair of small windshield chips or cracks in or the replacement of the entire windshield as a result of damage caused by road hazards;

(D) The repair of damage to the interior components of a motor vehicle caused by wear and tear but which expressly excludes the replacement of any part or component of a motor vehicle's interior;

(E) The replacement of a motor vehicle key or key fob in the event that the key or key fob becomes inoperable, lost or stolen;

(F) In conjunction with a motor vehicle leased for use, the repair, replacement or maintenance of property or indemnification for repair, replacement or maintenance due to excess wear and use, damage to items such as tires, paint cracks or chips, interior stains, rips or scratches, exterior dents or scratches, windshield cracks or chips, missing interior or exterior parts or excess mileage that result in a lease-end charge, or any other charge for damage that is deemed as excess wear and use by a lessor under a motor vehicle lease, provided that any repair, replacement, maintenance or indemnification shall not exceed the purchase price of the vehicle.

(x) "Service contract holder" or "contract holder" means a person who is the purchaser or holder of a service contract;

(xi) "Warranty" means a warranty made solely by the manufacturer, importer or seller of property or services without consideration, that is not negotiated or separated from the sale of the product and is incidental to the sale of the product, that guarantees indemnity for defective parts, mechanical or electrical breakdown, labor or other remedial measures, such as repair or replacement of the property or repetition of services;

(xii) "Incidental theft protection program payment" means expenses specified in a theft protection program warranty that are incurred by the warranty holder due to the failure of the warranty holder's theft protection program to perform as provided in the theft protection program warranty. Incidental theft protection program payments may include insurance policy deductibles, rental vehicle charges, the difference between the actual value of the stolen vehicle at the time of theft and the cost of a replacement vehicle, sales taxes, registration fees, transaction fees and mechanical inspection fees. Incidental theft protection program payments may be reimbursements in either a fixed amount specified in the theft protection program warranty or by use of a formula itemizing specific incidental theft protection program payments that may be due to the warranty holder;

(xiii) "Road hazard" means a hazard that is encountered while driving a motor vehicle and that may include, but is not limited to, potholes, rocks, wood debris, metal parts, glass, plastic, curbs or composite scraps;

(xiv) "Theft protection program" means a device or system that:

(A) Is installed on or applied to a motor vehicle and designed to prevent the theft of the vehicle or, if the vehicle is stolen, aid in the recovery of the vehicle;

(B) Includes a theft protection program warranty;

(C) May include but is not limited to:

(I) An alarm system;

(II) A body part marking product;

(III) A steering lock;

(IV) A window etch product;

(V) A pedal or ignition lock;

(VI) A fuel or ignition kill switch;

(VII) An electronic, radio or satellite tracking device.

(xv) "Theft protection program warranty" means a written agreement by a warrantor that provides if the theft protection program fails to prevent loss or damage to a motor vehicle from theft, the warrantor will pay to or on behalf of the warranty holder specified incidental theft protection program payments as a result of the failure of the theft protection program to perform pursuant to the terms of the theft protection program warranty.

26-49-103. Requirements for doing business.

(a) A provider may, but is not required to, appoint an administrator or other designee to be responsible for any or all of the administration of service contracts and compliance with this article.

(b) Service contracts shall not be issued, sold or offered for sale in this state unless the provider has:

(i) Provided a receipt for, or other written evidence of, the purchase of the service contract to the contract holder; and

(ii) Provided a copy of the service contract to the service contract holder within a reasonable period of time from the date of purchase.

(c) Each provider of service contracts sold in this state shall file a registration with the commissioner on a form prescribed by the commissioner. Each provider shall:

(i) Pay to the commissioner a fee in the amount of two hundred dollars ($200.00) annually;

(ii) Verify compliance annually with the faithful performance requirements specified in subsection (d) of this section on a form prescribed by the commissioner.

(d) In order to assure the faithful performance of a provider’s obligations to its service contract holders, each provider shall be responsible for complying with the requirements of any one (1) of the following paragraphs:

(i) Insure all service contracts under a reimbursement insurance policy issued by an insurer authorized to transact insurance in this state or issued pursuant to chapter 11 of this code;

(ii) Maintain a funded reserve account for its obligations under its service contracts issued and outstanding in this state. The reserves shall not be less than forty percent (40%) of the gross consideration received, less claims paid, on the sale of the service contract for all in force contracts. The reserve account shall be subject to examination and review by the commissioner. The provider shall also place in trust with the commissioner a financial security deposit, having a value of not less than five percent (5%) of the gross consideration received, less claims paid, on the sale of the service contract for all service contracts issued and in force, but not less than twenty-five thousand dollars ($25,000.00), consisting of one (1) of the following:

(A) A surety bond issued by an authorized surety;

(B) Securities of the type eligible for deposit by authorized insurers in this state;

(C) Cash;

(D) A letter of credit issued by a qualified financial institution; or

(E) Another form of security prescribed by regulations issued by the commissioner.

(iii) Maintain, or its parent company maintain, a net worth or stockholders' equity of at least one hundred million dollars ($100,000,000.00). The provider shall also upon request, provide the commissioner with a copy of provider's or the provider's parent company's most recent Form 10-K or Form 20-F filed with the securities and exchange commission within the last calendar year, or if the company does not file with the securities and exchange commission, a copy of the provider's or the provider's parent company's financial statements, which show a net worth of the provider or its parent company of at least one hundred million dollars ($100,000,000.00). If the provider's parent company's Form 10-K, Form 20-F or financial statements are filed to meet the provider's financial stability requirement, then the parent company shall agree to guarantee

the obligations of the provider relating to service contracts sold by the provider in this state.

(e) Service contracts shall require the provider to permit the original service contract holder to return the service contract within twenty (20) days of the date the service contract was mailed to the service contract holder or within ten (10) days of delivery if the service contract is delivered to the service contract holder at the time of sale or within a longer time period permitted under the service contract. Upon return of the service contract to the provider within the applicable time period, if no claim has been made under the service contract prior to its return to the provider, the service contract is void and the provider shall refund to the service contract holder, or credit the account of the service contract holder, with the full purchase price of the service contract. The right to void the service contract provided in this subsection is not transferable and shall apply only to the original service contract purchaser, and only if no claim has been made prior to its return to the provider. A ten percent (10%) penalty per month shall be added to a refund that is not paid or credited within forty-five (45) days after return of the service contract to the provider.

(f) Provider fees collected on service contracts shall not be subject to premium taxes. Premiums for reimbursement insurance policies shall be subject to applicable taxes.

(g) Except for the registration requirement in subsection (c) of this section, providers and related service contract sellers, administrators and other persons marketing, selling or offering to sell service contracts are exempt from any licensing requirements of this state.

(h) The marketing, sale, offering for sale, issuance, making, proposing to make and administration of service contracts by providers and related service contract sellers, administrators and other persons shall be exempt from all other provisions of this state's insurance law.

26-49-104. Required provisions; reimbursement insurance policy.

(a) Reimbursement insurance policies insuring service contracts issued, sold or offered for sale in this state shall state that the insurer that issued the reimbursement insurance policy shall reimburse or pay on behalf of the provider any

covered sums the provider is legally obligated to pay or shall provide the service which the provider is legally obligated to perform according to the provider's contractual obligations under the insured service contracts issued or sold by the provider.

(b) In the event covered service is not provided by the service contract provider within sixty (60) days of proof of loss by the service contract holder, the contract holder is entitled to apply directly to the reimbursement insurance company.

26-49-105. Required disclosures; service contracts.

(a) Service contracts marketed, sold, offered for sale, issued, made, proposed to be made, or administered in this state shall be written, printed or typed in clear, understandable language that is easy to read and shall disclose the requirements set forth in this section, as applicable.

(b) Service contracts insured under a reimbursement insurance policy pursuant to W.S. 26-49-103(d)(i) shall contain a statement in substantially the following form: "Obligations of the provider under this service contract are insured under a service contract reimbursement insurance policy." The service contract shall state the name and address of the insurer.

(c) Service contracts not insured under a reimbursement insurance policy pursuant to W.S. 26-49-103(d)(i) shall contain a statement in substantially the following form: "Obligations of the provider under this service contract are backed by the full faith and credit of the provider."

(d) Service contracts shall state the name and address of the provider and shall identify any administrator if different from the provider, the service contract seller, and the service contract holder to the extent that the name of the service contract holder has been furnished by the service contract holder. The identities of such parties are not required to be preprinted on the service contract and may be added to the service contract at the time of sale.

(e) Service contracts shall state the purchase price of the service contract and the terms under which the service contract is sold. The purchase price is not required to be preprinted on the service contract and may be negotiated at the time of sale with the service contract holder.

(f) Service contracts shall state the existence of any deductible amount, if applicable.

(g) Service contracts shall specify the merchandise and services to be provided and any limitations, exceptions or exclusions.

(h) Service contracts covering automobiles shall state whether the use of nonoriginal manufacturer's parts is allowed.

(j) Service contracts shall state any restrictions governing the transferability of the service contract, if applicable.

(k) Service contracts shall state the terms, restrictions or conditions governing cancellation of the service contract prior to the termination or expiration date of the service contract by either the provider or by the service contract holder. The provider of the service contract shall mail a written notice to the service contract holder at the last known address of the service contract holder contained in the records of the provider at least ten (10) days prior to cancellation by the provider. Prior notice is not required if the reason for cancellation is nonpayment of the provider fee, a material misrepresentation by the service contract holder to the provider or a substantial breach of duties by the service contract holder relating to the covered product or its use. The notice shall state the effective date of the cancellation and the reason for the cancellation.

(m) Service contracts shall set forth the obligations and duties of the service contract holder, such as the duty to protect against any further damage and any requirement to follow owner's manual instructions.

(n) Service contracts shall state whether or not the service contract provides for or excludes consequential damages or preexisting conditions, if applicable.

26-49-106. Prohibited acts.

(a) A provider shall not use in its name the words insurance, casualty, surety, mutual or any other words descriptive of the insurance, casualty or surety business; or a name deceptively similar to the name or description of any insurance or surety corporation, or to the name of any other

provider. The word "guaranty" or similar word may be used by a provider. This section shall not apply to a company that was using any of the prohibited language in its name prior to April 1, 1999. However, a company using the prohibited language in its name shall include in its service contracts a statement in substantially the following form: "This agreement is not an insurance contract."

(b) A provider or its representative shall not in its service contracts or literature make, permit or cause to be made any false or misleading statement, or deliberately omit any material statement that would be considered misleading if omitted.

(c) A person, such as a bank, savings and loan association, lending institution, manufacturer or seller of any product, shall not require the purchase of a service contract as a condition of a loan or a condition for the sale of any property.

26-49-107. Record keeping requirements.

(a) The provider shall keep accurate accounts, books, and records concerning transactions regulated under this article. The provider's accounts, books and records shall include the following:

(i) Copies of each type of service contract sold;

(ii) The name and address of each service contract holder, to the extent that the name and address have been furnished by the service contract holder;

(iii) A list of the locations where service contracts are marketed, sold or offered for sale;

(iv) Written claims files, which shall contain at least the dates and description of claims related to the service contracts.

(b) Except as provided in subsection (d) of this section, the provider shall retain all records required to be maintained by this section for at least one (1) year after the specified period of coverage has expired.

(c) The records required under this article may be, but are not required to be, maintained on a computer disk or other

record keeping technology. If the records are maintained in other than hard copy, the records shall be capable of duplication to legible hard copy at the request of the commissioner.

(d) A provider discontinuing business in this state shall maintain its records until it furnishes the commissioner satisfactory proof that it has discharged all obligations to service contract holders in this state.

26-49-108. Cancellation of reimbursement insurance policy.

As applicable, an insurer that issued a reimbursement insurance policy shall not terminate the policy until a notice of termination in accordance with chapter 35 of this code, has been mailed or delivered to the commissioner. The termination of a reimbursement insurance policy shall not reduce the issuer's responsibility for service contracts issued by providers prior to the date of the termination.

26-49-109. Obligations of reimbursement insurance policy insurers.

(a) Providers are considered to be the agent of the insurer which issued the reimbursement insurance policy for purposes of obligating the insurer to service contract holders in accordance with the service contract and this article. In cases where a provider is acting as an administrator and enlists other providers, the provider acting as the administrator shall notify the insurer of the existence and identities of the other providers.

(b) This article shall not prevent or limit the right of an insurer which issued a reimbursement insurance policy to seek indemnification or subrogation against a provider if the issuer pays or is obligated to pay the service contract holder sums that the provider was obligated to pay pursuant to the provisions of the service contract.

26-49-110. Enforcement provisions.

(a) The commissioner may conduct examinations of providers, administrators, insurers or other persons to enforce this article and protect service contract holders in this state. Upon request of the commissioner, the provider shall make all accounts, books and records concerning service contracts sold by the provider available to the commissioner which are necessary

to enable the commissioner to reasonably determine compliance or noncompliance with this article.

(b) The commissioner may take action which is necessary or appropriate to enforce the provisions of this article and the commissioner's regulations and orders, and to protect service contract holders in this state.

(c) If a provider has violated this article or the commissioner's regulations or orders, the commissioner may issue an order directed to that provider to cease and desist from committing violations of this article or the commissioner's regulations or orders; may issue an order prohibiting that provider from selling or offering for sale service contracts in violation of this article; or may issue an order imposing a civil penalty on that provider; or any combination of the foregoing, as applicable. A person aggrieved by an order issued under this section may request a hearing before the commissioner pursuant to W.S. 26-2-125.

(d) The commissioner may bring an action in any court of competent jurisdiction, for an injunction or other appropriate relief to enjoin threatened or existing violations of this article or of the commissioner's orders or regulations. An action filed under this section also may seek restitution on behalf of persons aggrieved by a violation of this article or orders or regulations of the commissioner.

(e) A person who is found to have violated this article or orders or regulation of the commissioner may be ordered to pay to the commissioner a civil penalty in an amount determined by the commissioner of not more than five hundred dollars ($500.00) per violation and no more than ten thousand dollars ($10,000.00) in the aggregate for all violations of a similar nature. For purposes of this section, violations shall be of a similar nature if the violation consists of the same or similar course of conduct, action or practice, irrespective of the number of times the act, conduct or practice which is determined to be a violation of this article occurred.

26-49-111. Authority to develop regulations.

The commissioner may promulgate reasonable rules and regulations necessary to implement this article.

26-50-101. Repealed By Laws 2013, Ch. 123, § 3.

26-50-102. Repealed By Laws 2013, Ch. 123, § 3.

26-50-103. Repealed By Laws 2013, Ch. 123, § 3.

26-50-104. Repealed By Laws 2013, Ch. 123, § 3.

26-50-105. Repealed By Laws 2013, Ch. 123, § 3.

26-50-106. Repealed By Laws 2013, Ch. 123, § 3.

26-50-107. Repealed By Laws 2013, Ch. 123, § 3.

26-50-108. Repealed By Laws 2013, Ch. 123, § 3.

26-50-109. Repealed By Laws 2013, Ch. 123, § 3.

CHAPTER 51 - OWN RISK SOLVENCY

26-51-101. Purpose and scope.

The requirements of this chapter shall apply to all insurers domiciled in this state unless exempt pursuant to W.S. 26-51-106.

26-51-102. Definitions.

(a) As used in this chapter:

(i) "Insurance group" means those insurers and affiliates included within an insurance holding company system as defined in W.S. 26-44-101(a)(iv);

(ii) "Insurer" shall have the same meaning as set forth in W.S. 26-1-102(a)(xvi), except that it shall not include 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;

(iii) "Own risk and solvency assessment" or "ORSA" means a confidential internal assessment, appropriate to the nature, scale and complexity of an insurer or insurance group, conducted by that insurer or insurance group of the material and relevant risks associated with the insurer or insurance group's

current business plan, and the sufficiency of capital resources to support those risks;

(iv) "ORSA guidance manual" means the current version of the Own Risk and Solvency Assessment Guidance Manual developed and adopted by the National Association of Insurance Commissioners (NAIC) and as amended from time to time. A change in the ORSA guidance manual shall be effective on January 1 following the calendar year in which the changes have been adopted by the NAIC;

(v) "ORSA summary report" means a confidential high-level summary of an insurer or insurance group's ORSA.

26-51-103. Risk management framework.

An insurer shall maintain a risk management framework to assist the insurer with identifying, assessing, monitoring, managing and reporting on its material and relevant risks. This requirement may be satisfied if the insurance group of which the insurer is a member maintains a risk management framework applicable to the operations of the insurer.

26-51-104. ORSA requirement.

Subject to W.S. 26-51-106, an insurer, or the insurance group of which the insurer is a member, shall regularly conduct an ORSA consistent with a process comparable to the ORSA guidance manual. The ORSA shall be conducted no less than annually but also at any time when there are significant changes to the risk profile of the insurer or the insurance group of which the insurer is a member.

26-51-105. ORSA summary report.

(a) Upon the commissioner's request, and no more than once each year, an insurer shall submit to the commissioner an ORSA summary report or any combination of reports that together contain the information described in the ORSA guidance manual, applicable to the insurer and the insurance group of which it is a member. Notwithstanding any request from the commissioner, if the insurer is a member of an insurance group, the insurer shall submit the report required by this subsection if the commissioner is the lead state commissioner of the insurance group as determined by the procedures within the financial analysis handbook adopted by the NAIC.

(b) The report shall include a signature of the insurer or insurance group's chief risk officer or other executive having responsibility for the oversight of the insurer's enterprise risk management process attesting to the best of his belief and knowledge that the insurer applies the enterprise risk management process described in the ORSA summary report and that a copy of the report has been provided to the insurer's board of directors or the appropriate committee thereof.

(c) An insurer may comply with subsection (a) of this section by providing the most recent and substantially similar report provided by the insurer or another member of an insurance group of which the insurer is a member to the commissioner of another state or to a supervisor or regulator of a foreign jurisdiction, if that report provides information that is comparable to the information described in the ORSA guidance manual. Any report in a language other than English shall be accompanied by a translation of that report into the English language.

26-51-106. Exemption.

(a) An insurer shall be exempt from the requirements of this chapter, if:

(i) The insurer has annual direct written and unaffiliated assumed premium, including international direct and assumed premium but excluding premiums reinsured with the federal crop insurance corporation and federal flood program, of less than five hundred million dollars ($500,000,000.00); and

(ii) The insurance group of which the insurer is a member has annual direct written and unaffiliated assumed premium including international direct and assumed premium, but excluding premiums reinsured with the federal crop insurance corporation and federal flood program, of less than one billion dollars ($1,000,000,000.00).

(b) If an insurer qualifies for exemption pursuant to paragraph (a)(i) of this section, but the insurance group of which the insurer is a member does not qualify for exemption pursuant to paragraph (a)(ii) of this section, then the ORSA summary report that may be required pursuant to W.S. 26-51-105 shall include every insurer within the insurance group. This requirement may be satisfied by the submission of more than one (1) ORSA summary report for any combination of insurers provided

any combination of reports includes every insurer within the insurance group.

(c) If an insurer does not qualify for exemption pursuant to paragraph (a)(i) of this section, but the insurance group of which it is a member qualifies for exemption pursuant to paragraph (a)(ii) of this section, then the only ORSA summary report that may be required pursuant to W.S. 26-51-105 shall be the report applicable to that insurer.

(d) An insurer that does not qualify for exemption pursuant to subsection (a) of this section may apply to the commissioner for a waiver from the requirements of this chapter based upon unique circumstances. In deciding whether to grant the insurer's request for waiver, the commissioner may consider the type and volume of business written, ownership and organizational structure and any other factor the commissioner considers relevant to the insurer or insurance group of which the insurer is a member. If the insurer is part of an insurance group with insurers domiciled in more than one (1) state, the commissioner shall coordinate with the lead state commissioner and with the other domiciliary commissioners in considering whether to grant the insurer's request for a waiver.

(e) Notwithstanding the exemptions stated in this section:

(i) The commissioner may require that an insurer maintain a risk management framework, conduct an ORSA and file an ORSA summary report based on unique circumstances including, but not limited to, the type and volume of business written, ownership and organizational structure, federal agency requests and international supervisor requests;

(ii) The commissioner may require that an insurer maintain a risk management framework, conduct an ORSA and file an ORSA summary report if the insurer has risk-based capital for company action level event as set forth in W.S. 26-48-103 and 26-48-203, meets one (1) or more of the standards of an insurer deemed to be in hazardous financial condition as defined in W.S. 26-3-116, or otherwise exhibits qualities of a troubled insurer as determined by the commissioner.

(f) If an insurer that qualifies for an exemption pursuant to subsection (a) of this section subsequently no longer qualifies for that exemption due to changes in premium as reflected in the insurer's most recent annual statement or in the most recent annual statements of the insurers within the

insurance group of which the insurer is a member, the insurer shall have one (1) year following the year the threshold is exceeded to comply with the requirements of this chapter.

26-51-107. Contents of ORSA summary report.

(a) The ORSA summary report shall be prepared consistent with the ORSA guidance manual, subject to the requirements of subsection (b) of this section. Documentation and supporting information shall be maintained and made available upon examination or upon request of the commissioner.

(b) The review of the ORSA summary report, and any additional requests for information, shall be made using similar procedures currently used in the analysis and examination of multi-state or global insurers and insurance groups.

26-51-108. Confidentiality.

(a) Documents, materials or other information, including the ORSA summary report, in the possession of or control of the department that are obtained by, created by or disclosed to the commissioner or any other person under this chapter, is recognized by this state as being proprietary and to contain trade secrets. All such documents, materials or other information shall be confidential by law and privileged, shall not be subject to the Wyoming Public Records Act, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties. The commissioner shall not otherwise make the documents, materials or other information public without the prior written consent of the insurer.

(b) Neither the commissioner nor any person who received documents, materials or other ORSA-related information, through examination or otherwise, while acting under the authority of the commissioner or with whom those documents, materials or other information are shared pursuant to this chapter shall be permitted or required to testify in any private civil action concerning any confidential documents, materials or information subject to subsection (a) of this section.

(c) In order to assist in the performance of the commissioner's regulatory duties, the commissioner:

(i) May, upon request, share documents, materials or other ORSA-related information, including the confidential and privileged documents, materials or information subject to subsection (a) of this section, including proprietary and trade secret documents and materials with other state, federal and international financial regulatory agencies, including members of any supervisory college as defined in W.S. 26-44-118, with the NAIC and with any third-party consultants designated by the commissioner, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the ORSA-related documents, materials or other information and has verified in writing the legal authority to maintain confidentiality; and

(ii) May receive documents, materials or other ORSA-related information, including otherwise confidential and privileged documents, materials or information, including proprietary and trade-secret information or documents, from regulatory officials of other foreign or domestic jurisdictions, including members of any supervisory college as defined in W.S. 26-44-118, and from the NAIC, and shall maintain as confidential or privileged any documents, materials or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information;

(iii) Shall enter into a written agreement with the NAIC or a third-party consultant governing sharing and use of information provided pursuant to this chapter, consistent with this subsection that shall:

(A) Specify procedures and protocols regarding the confidentiality and security of information shared with the NAIC or a third-party consultant pursuant to this chapter, including procedures and protocols for sharing by the NAIC with other state regulators from states in which the insurance group has domiciled insurers. The agreement shall provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the ORSA-related documents, materials or other information and has verified in writing the legal authority to maintain confidentiality;

(B) Specify that ownership of information shared with the NAIC or a third-party consultant pursuant to this chapter remains with the commissioner and the NAIC's or a third-

party consultant's use of the information is subject to the direction of the commissioner;

(C) Prohibit the NAIC or third-party consultant from storing the information shared pursuant to this chapter in a permanent database after the underlying analysis is completed;

(D) Require prompt notice to be given to an insurer whose confidential information in the possession of the NAIC or a third-party consultant pursuant to this chapter is subject to a request or subpoena to the NAIC or a third-party consultant for disclosure or production;

(E) Require the NAIC or a third-party consultant to consent to intervention by an insurer in any judicial or administrative action in which the NAIC or a third-party consultant may be required to disclose confidential information about the insurer shared with the NAIC or a third-party consultant pursuant to this chapter; and

(F) In the case of an agreement involving a third-party consultant, provide for the insurer's written consent.

(d) The sharing of information and documents by the commissioner pursuant to this chapter shall not constitute a delegation of regulatory authority or rulemaking, and the commissioner is solely responsible for the administration, execution and enforcement of the provisions of this chapter.

(e) No waiver of any applicable privilege or claim of confidentiality in the documents, proprietary and trade-secret materials or other ORSA-related information shall occur as a result of disclosure of such ORSA-related information or documents to the commissioner under this section or as a result of sharing as authorized in this chapter.

(f) Documents, materials or other information in the possession or control of the NAIC or a third-party consultant pursuant to this chapter shall be confidential by law and privileged, shall not be subject to the Wyoming Public Records Act, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.

26-51-109. Sanctions.

Any insurer failing, without just cause, to timely file the ORSA summary report as required in this chapter shall be required, after notice and hearing, to pay a penalty of two thousand five hundred dollars ($2,500.00) for each day's delay, to be recovered by the commissioner. The maximum penalty under this section is seventy-five thousand dollars ($75,000.00). The commissioner may reduce the penalty if the insurer demonstrates to the commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.

26-51-110. Applicability.

The requirements of this chapter shall become effective on January 1, 2015. The first filing of the ORSA summary report shall be in 2015 pursuant to W.S. 26-51-105.

CHAPTER 52 - PHARMACY BENEFIT MANAGERS AND PAYMENT OF PHARMACY CLAIMS

ARTICLE 1 - PHARMACY BENEFIT MANAGERS

26-52-101. Licensure of pharmacy benefit managers.

No person shall act or hold himself out as a pharmacy benefit manager in this state unless he obtains a license from the department. The department shall through rules establish license requirements and procedures for the licensing of pharmacy benefit managers consistent with this article. The requirements shall only provide for the adequate identification of licensees and the payment of the required licensing fee.

26-52-102. Definitions.

(a) As used in this article:

(i) "Claim" means a request from a pharmacy or pharmacist to be reimbursed for the cost of filling or refilling a prescription for a drug or for providing a medical supply or device;

(ii) "Insurer" means the entity defined in W.S. 26-1-102(a)(xvi) and who provides health insurance coverage in this state;

(iii) "List" means the list of drugs for which a pharmacy benefit manager has established a maximum allowable cost;

(iv) "Maximum allowable cost" means the maximum amount that a pharmacy benefit manager will reimburse a pharmacist or pharmacy for the cost of a generic drug;

(v) "Network providers" means those pharmacies that provide covered health care services or supplies to an insured or a member pursuant to a contract with a network plan to act as a participating provider;

(vi) "Pharmacy" means an entity through which pharmacists or other persons practice pharmacy as specified in W.S. 33-24-124;

(vii) "Pharmacy benefit manager" means an entity that contracts with a pharmacy or the pharmacy's designee who holds a contract with the pharmacy benefit manager on behalf of an insurer or third party administrator to administer or manage prescription drug benefits;

(ix) "Pharmacy services" means any product, good or service, or any combination of products, goods or services, provided as part of the practice of pharmacy;

(x) "Pharmacy services administrative organization" means an organization that evaluates and executes pharmacy benefit manager contracts on behalf of pharmacies and provides administrative, clerical, audit and data analytics support services.

26-52-103. Pharmacy benefit manager audits.

(a) Any pharmacy benefit manager or person acting on behalf of a pharmacy benefit manager who conducts an audit of a pharmacy shall follow the following procedures:

(i) Provide written notice to the pharmacy not less than ten (10) business days before conducting any on-site, initial audit;

(ii) Conduct any audit requiring clinical or professional judgment through or in consultation with a licensed pharmacist;

(iii) Limit the period covered by the audit to not more than two (2) years from the date that an audited claim was adjudicated;

(iv) Allow verifiable statements or records, including medication administration records of a nursing home, assisted living facility, hospital, physician or other authorized practitioner, to validate the pharmacy record;

(v) Allow legal prescriptions, including medication administration records, faxes, electronic prescriptions or documented telephone calls from the prescriber or the prescriber's agent, to validate claims in connection with prescriptions, refills or changes in prescriptions;

(vi) Apply the same standards and parameters to each audited pharmacy as are applied to other similarly situated pharmacies in a pharmacy network contract in this state;

(vii) Not conduct any audit provided for in this section during the first seven (7) calendar days of any month without the consent of the audited pharmacy; and

(viii) Establish a written appeals process and provide a copy to every audited pharmacy.

(b) A pharmacy benefit manager or person acting on behalf of a pharmacy benefit manager who conducts an audit of a pharmacy also shall comply with the following requirements:

(i) Any finding of overpayment or underpayment shall be based on the actual overpayment or underpayment and not on a projection based on the number of patients served having a similar diagnosis or on the number of similar orders or refills for similar drugs;

(ii) Any finding of an overpayment shall not include the dispensing fee amount unless:

(A) A prescription was not received by the patient or the patient's designee;

(B) The prescriber denied authorization;

(C) The prescription dispensed was a medication error by the pharmacy; or

(D) The identified overpayment is based solely on an extra dispensing fee.

(iii) No audit shall use extrapolation in calculating the recoupments or penalties for audits, unless required by state or federal contracts;

(iv) No payment for the performance of an audit shall be based on a percentage of the amount recovered;

(v) Interest shall not accrue during the audit period;

(vi) No audit shall consider any clerical or recordkeeping error, such as a typographical error, scrivener's error or computer error regarding a required document or record, as fraud. These errors may be subject to recoupment. No recovery shall be assessed for errors causing no financial harm to the patient or plan. Errors that are the result of a pharmacy failing to comply with a formal corrective action plan may be subject to recovery. Any recoupment shall be based on the actual overpayment of a claim;

(vii) A preliminary audit report shall be delivered to the audited pharmacy within one hundred twenty (120) days after the conclusion of the audit;

(viii) A pharmacy shall be allowed at least thirty (30) days following receipt of the preliminary audit report to provide documentation addressing any audit finding, and a reasonable extension of time shall be granted upon request;

(ix) A final audit report shall be delivered to the pharmacy not more than one hundred twenty (120) days after the preliminary audit report is received by the pharmacy or submission of final internal appeal, whichever is later;

(x) Recoupment of any disputed funds or repayment of funds to the pharmacy benefit manager or insurer by the pharmacy, if permitted pursuant to contracts, shall occur, to the extent demonstrated or documented in the pharmacy audit findings, after final internal disposition of the audit including the appeals process. If the identified discrepancy for an individual audit exceeds fifteen thousand dollars ($15,000.00), any future payments to the pharmacy may be withheld pending finalization of the audit;

(xi) No chargebacks, recoupment or other penalties may be assessed until the appeal process has been exhausted and the final report issued.

(c) Subsections (a) and (b) of this section shall not apply to:

(i) Audits in which suspected fraudulent activity or other intentional or willful misrepresentation is evidenced by a physical review, review of claims data, statements or other investigative methods; or

(ii) Audits of claims paid for by federally funded programs.

(d) This section shall apply to a contracted pharmacy, or the pharmacy's designee who holds a contract with a pharmacy benefit manager, entered into, renewed or extended on or after July 1, 2016, and to all audits of pharmacies on and after July 1, 2017.

26-52-104. Maximum allowable cost; offering information and alternatives.

(a) To place a drug on a maximum allowable cost list, a pharmacy benefit manager shall ensure that the drug is:

(i) If the drug is a generically equivalent drug, rated "A" or "B" in the most recent version of the United States Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations (Orange Book), or rated "NR" or "NA," or has a similar rating, by a nationally recognized reference;

(ii) Generally available for purchase by retail pharmacies in the state from national or regional wholesalers;

(iii) Not obsolete or temporarily unavailable.

(b) In formulating the maximum allowable cost price for a drug, an insurer or pharmacy benefit manager shall consider only the price of that drug and any drug listed as therapeutically equivalent to that drug in the most recent version of the United States Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations (Orange Book).

(c) Notwithstanding subsection (b) of this section, if a therapeutically equivalent generic drug is unavailable or has limited market presence, an insurer or pharmacy benefit manager may place on a maximum allowable cost list a drug that has:

(i) A "B" rating in the most recent version of the United States Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations (Orange Book); or

(ii) An "NR" or "NA" rating, or a similar rating, by a nationally recognized reference.

(d) A pharmacy benefit manager shall:

(i) Make available to each network provider at the beginning of the term of the network provider's contract, and upon renewal of the contract, the sources utilized to determine the maximum allowable cost pricing;

(ii) Provide a telephone number, email address and website at which a network pharmacy or the pharmacy's designee who holds a contract with the pharmacy benefit manager may contact an employee of a pharmacy benefit manager to discuss the pharmacy's appeal;

(iii) Provide a process for network providers to readily access the maximum allowable cost applicable to that provider;

(iv) Review and update applicable maximum allowable cost price information at least once every seven (7) business days to reflect any modification of maximum allowable cost pricing; and

(v) Ensure that dispensing fees are not included in the calculation of maximum allowable cost.

(e) A pharmacy benefit manager shall establish a process by which a contracted pharmacy, or the pharmacy's designee who holds a contract with the pharmacy benefit manager, can appeal the provider's reimbursement for a drug subject to maximum allowable cost pricing. A contracted pharmacy, or the pharmacy's designee who holds a contract with the pharmacy benefit manager, shall have up to ten (10) business days after dispensing a drug subject to a maximum allowable cost in which to appeal the amount of the maximum allowable cost. A pharmacy benefit manager shall respond to the appeal within ten (10) business days after the contracted pharmacy or the pharmacy's designee who holds a contract with the pharmacy benefit manager makes the appeal.

(f) If a maximum allowable cost appeal is denied, the pharmacy benefit manager shall provide to the appealing pharmacy, or the pharmacy's designee who holds a contract with the pharmacy benefit manager, the reason for the denial and the national drug code number for the drug that is available for purchase by similarly situated pharmacies in the state and the names of national or regional wholesalers that have the product available for purchase at a price that is at or below the maximum allowable cost.

(g) If an appeal is upheld, the pharmacy benefit manager shall make an adjustment to the applicable maximum allowable cost no later than one (1) day after the date of the determination and make the adjustment applicable to all similarly situated network pharmacy providers, as determined by the insurer or pharmacy benefit manager. The pharmacy benefit manager shall allow the appealing pharmacy to reverse and rebill the claim which was the subject of the appeal.

(h) This section shall apply to a contracted pharmacy, or the pharmacy's designee who holds a contract with a pharmacy benefit manager, entered into, renewed or extended on or after July 1, 2016, and to contracts on and after July 1, 2017.

(j) A pharmacy benefit manager may not, by contract or otherwise, prohibit or penalize a pharmacy or pharmacist for:

(i) Disclosing information to a covered individual regarding any cost differential that the covered individual must pay for a particular prescription under the individual's prescription drug benefit or outside of the individual's prescription drug benefit;

(ii) Offering to a covered individual a more affordable alternative if one is available.

(k) A pharmacy benefit manager shall not prevent a network pharmacy or the pharmacy's designee who holds a contract with the pharmacy benefit manager from filing appeals in an electronic batch format. The pharmacy benefit manager shall respond in an electronic format to valid reimbursement appeals filed in an electronic batch format. A batch appeal shall not be considered a valid appeal unless all required information for each claim in the batch is submitted electronically with the correct, contractually required information and in the required format. An appeal shall not be considered valid for purposes of

the ten (10) day response timeframe until all information is received.

(m) A pharmacy or pharmacist may decline to provide pharmacy services to a patient or pharmacy benefit manager if the pharmacy or pharmacist is to be paid less than the pharmacy acquisition cost for the pharmacy providing pharmacy services.

26-52-105. Transparency; prohibitions.

(a) A pharmacy benefit manager or an agent of a pharmacy benefit manager shall not:

(i) Cause or knowingly permit the use of an advertisement, promotion, solicitation, representation, proposal or offer that is untrue, deceptive or misleading;

(ii) Charge a pharmacist or pharmacy provider a fee for any of the following:

(A) The submission of a claim;

(B) Enrollment or participation in a retail pharmacy network;

(C) The development or management of claims processing services or claims payment services related to participation in a retail pharmacy network;

(D) An application to apply for network access with the pharmacy benefit manager;

(E) Credentialing or re-credentialing.

(iii) Retroactively deny or reduce reimbursement for a covered pharmacy service or claim after adjudication of the claim, unless:

(A) The original claim was fraudulent; or

(B) The denial or reduction is necessary to correct errors found in an audit, provided that the audit was conducted in compliance with W.S. 26-52-103.

(vii) Prohibit a pharmacy, pharmacy services administrative organization, contracting agent or agent of a

pharmacy from sharing, upon request, copies of pharmacy benefit manager contracts with the department of insurance;

(viii) Prohibit, restrict or limit disclosure of information to the insurance commissioner, law enforcement or other state or federal government officials who are investigating or examining a complaint or conducting a review of the pharmacy benefit manager's compliance with the requirements of this chapter.

(c) Insurers, pharmacies and pharmacy benefit managers shall adhere to all state laws and rules when mailing or shipping prescription drugs into the state.

26-52-106. Alternate reimbursement methodologies.

All contracts between a pharmacy benefits manager and a pharmacy services administrative organization, or its contracted pharmacies, and all contracts directly between a pharmacy benefits manager and a pharmacy shall include a process to investigate and resolve disputes.

26-52-107. Certain claims excluded.

W.S. 26-52-104 through 26-52-106 shall apply to all health benefit plan issuers and pharmacy benefit managers except those claims associated with the Wyoming Medicaid fee-for-service program, the Wyoming workers compensation division or those claims otherwise prohibited by federal law.

ARTICLE 2 - PAYMENT OF INSURANCE CLAIMS

26-52-201. Scope and applicability of chapter.

The following provisions apply to situations where there is a contract between an insurer or the insurer's intermediary and a pharmacy regarding the payment of insurance claims for pharmacy services pursuant to W.S. 26-52-102(a)(ix) submitted to an insurer or the insurer's intermediary.

26-52-202. Definitions.

(a) As used in this chapter:

(i) "Applicable number of calendar days" means:

(A) For claims submitted electronically, twenty-one (21) days;

(B) For claims submitted in a manner other than electronically, thirty (30) days.

(ii) "Clean claim" means a claim that has no defect, including any lack of required substantiating documentation or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this chapter;

(iii) "Insurer" means as defined by W.S. 26-1-102(a)(xvi).

26-52-203. Payment of claims to pharmacy providers.

(a) A contract between an insurer or the insurer's intermediary and a pharmacy for prescription drug coverage offered by the insurer or the insurer's intermediary shall require the insurer or the insurer's intermediary to make payment to the pharmacy for all clean claims submitted by a pharmacy within the applicable number of calendar days after the date that the clean claim is received. For purposes of this section, a claim is considered to have been received:

(i) For claims submitted electronically, on the date that the claim is submitted; or

(ii) For claims submitted in any manner other than electronically, on the fifth day after the postmark date of the claim or the date specified on the time stamp of the transmission of the claim.

(b) For purposes of this section, a contract between an insurer or the insurer's intermediary and a pharmacy regarding prescription drug coverage offered by an insurer or the insurer's intermediary shall include any contract regarding prescription drug coverage offered by the insurer or the insurer's intermediary under which a pharmacy is legally obligated, either directly or through an intermediary such as a pharmacy benefit manager.

(c) If the insurer or the insurer's intermediary does not make payment within the applicable number of calendar days after a clean claim is received, or resubmitted under subsections (e) and (f) of this section, the insurer or the insurer's

intermediary shall pay interest to the pharmacy at the rate of eighteen percent (18%) per annum, billed weekly.

(d) A claim shall be considered a clean claim if the insurer or the insurer's intermediary does not provide notice to the pharmacy of any deficiency in the claim within ten (10) days after an electronically submitted claim is received or within fifteen (15) days after a claim that is submitted in any other manner is received.

(e) If an insurer or the insurer's intermediary determines that a claim submitted is not a clean claim, the insurer or the insurer's intermediary shall notify the pharmacy of the determination within ten (10) days of receiving an electronically submitted claim or within fifteen (15) days of receiving a claim that is submitted in any other manner. The notice shall specify all defects in the claim and list all information or documents necessary for the proper processing and payment of the claim.

(f) A claim resubmitted to an insurer or the insurer's intermediary with additional information pursuant to subsection (e) of this section shall be considered to be a clean claim if the insurer or the insurer's intermediary fails to provide notice to the pharmacy of any defect in the claim within ten (10) days of the date that additional information is received if the claim is resubmitted electronically or within fifteen (15) days of the date that additional information is received if the claim is resubmitted in any other manner. A resubmitted claim that is considered to be a clean claim under this subsection shall be paid within the applicable number of calendar days after the date that the resubmitted claim is received and, if payment is not timely made, interest shall accrue as provided by subsection (c) of this section.

(g) Payment of a clean claim under this section shall be considered to have been made on the date that the payment is transferred to the pharmacy provider account, or to the central pay account of the pharmacy services administrative organization that is directly contracted by the pharmacy, with respect to claims paid electronically and on the date that the payment is submitted to the postal service or common carrier for delivery with respect to claims paid in any other manner.

(h) No insurer shall directly or indirectly charge a pharmacy or hold the pharmacy responsible for fees associated with claims payment.

CHAPTER 53 - THIRD PARTY ADMINISTRATORS

26-53-101. Definitions.

(a) As used in this chapter:

(i) "Third party administrator" means a person who directly or indirectly underwrites, collects charges, collateral or premiums from, or adjusts or settles claims on residents of this state, in connection with life, annuity, health, or stop-loss coverage offered or provided by an insurer, but does not include any of the following:

(A) An employer on behalf of its employees or the employees of one (1) or more subsidiary or affiliated corporations of such employer;

(B) A union on behalf of its members;

(C) A fully self-funded insurance plan meeting the definition of employee benefit plan as set forth in the Employee Retirement Income Security Act of 1974;

(D) An insurance company licensed in this state;

(E) A prepaid hospital or medical care plan;

(F) An insurance agent or broker licensed in this state when acting as an insurance agent or broker;

(G) A creditor on behalf of its debtors with respect to insurance covering a debt between the creditor and its debtors;

(H) A bank, credit union or other financial institution which is subject to supervision or examination by federal or state banking authorities when acting as a bank, credit union or other financial institution and not as an administrator;

(J) A credit card company which advances for and collects premiums or charges from its credit card holders who have authorized it to do so, provided such company does not adjust or settle claims;

(K) A person who adjusts or settles claims in the normal course of the person's practice or employment as an attorney at law or an adjuster licensed in this state and who does not collect charges or premiums in connection with insurance coverage or annuities.

26-53-102. Registration of third party administrators; rulemaking authority.

No person shall act as a third party administrator in this state without a certificate of registration issued by the commissioner. The commissioner in compliance with the Wyoming Administrative Procedure Act shall promulgate reasonable rules and regulations necessary to implement this chapter.

26-53-103. Third party administrator fee.

Every third party administrator registered with the department shall pay the fee provided for in W.S. 26-4-101(a)(xix).

CHAPTER 54 - CORPORATE GOVERNANCE ANNUAL DISCLOSURE

26-54-101. Short title; applicability.

(a) This chapter is known and may be cited as the Wyoming Insurance Corporate Governance Annual Disclosure Act.

(b) The requirements of this act shall apply to all insurers and insurance groups domiciled in this state.

(c) Nothing in this act shall be construed to prescribe or impose corporate governance standards and internal procedures beyond that which is required under the corporate law of this state.

(d) Nothing in this act shall be construed to limit the commissioner's authority, or the rights or obligations of third parties, pursuant to the Wyoming Insurance Code.

(e) No insurer or insurance group shall be required to file the disclosure required by this act until 2020.

26-54-102. Definitions.

(a) As used in this act:

(i) "Corporate governance" means the system of rules, practices and procedures by which a corporation is managed by its directors and officers;

(ii) "Corporate governance annual disclosure" or "CGAD" means a confidential report filed by an insurer or insurance group in accordance with the requirements of this act;

(iii) "Insurance group" means those insurers and affiliates included within an insurance holding company system as defined under W.S. 26-44-101(a)(iv);

(iv) "Insurer" shall have the same meaning as set forth under W.S. 26-1-102(a)(xvi) and include domestic fraternal benefit societies and health maintenance organizations. This term shall not include 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.

26-54-103. Disclosure requirement.

(a) An insurer, or the insurance group of which the insurer is a member, shall, no later than June 1 of each calendar year, submit to the commissioner a corporate governance annual disclosure that contains the information described in W.S. 26-54-105. Notwithstanding any request from the commissioner made pursuant to subsection (c) of this section, if the insurer is a member of an insurance group, the insurer shall submit the report required by this section to the commissioner of insurance of the lead state for the insurance group, in accordance with the laws of the lead state and under the guidance of the procedures outlined in the most recent financial analysis handbook adopted by the National Association of Insurance Commissioners.

(b) The CGAD shall include a signature of the insurer's or insurance group's chief executive officer or corporate secretary attesting to the best of that individual's belief and knowledge that the insurer has implemented the corporate governance practices disclosed pursuant to subsection (a) of this section and that a copy of the disclosure has been provided to the insurer's board of directors or the appropriate committee thereof.

(c) An insurer not required to submit a CGAD under this section shall do so upon the commissioner's request.

(d) For purposes of completing the CGAD, the insurer or insurance group may provide information regarding corporate governance at the ultimate controlling parent level, an intermediate holding company level or the individual legal entity level, depending upon how the insurer or insurance group has structured its system of corporate governance. The insurer or insurance group is encouraged to make the CGAD disclosures at the level at which the insurer's or insurance group's risk appetite is determined, or at which the earnings, capital, liquidity, operations, and reputation of the insurer are overseen collectively and at which the supervision of those factors are coordinated and exercised, or the level at which legal liability for failure of general corporate governance duties would be placed. If the insurer or insurance group determines the level of reporting based on these criteria, it shall indicate which of the three (3) criteria was used to determine the level of reporting and explain any subsequent changes in the level of reporting.

(e) The review of the CGAD and any additional requests for information shall be made through the lead state under the guidance of the procedures contained in the most recent financial analysis handbook referenced in subsection (a) of this section.

(f) Insurers providing information substantially similar to the information required by this act in other documents provided to the commissioner, including any statements filed pursuant to W.S. 26-44-104, or other state or federal filings provided to the department, shall not be required to duplicate that information in the CGAD, but shall be required to cross reference and identify where the document may be located by the commissioner.

26-54-104. Rules and regulations.

The commissioner shall promulgate rules and regulations necessary to carry out the provisions of this act. The rules and regulations shall be consistent with this act and the commissioner shall be guided by the model regulations adopted by the National Association of Insurance Commissioners at its 2014 fall national meeting and subsequent provisions of those model regulations, provided the model regulations are consistent with this act and other relevant provisions of Wyoming law and are not inappropriate for Wyoming circumstances.

26-54-105. Contents of corporate governance annual disclosure.

(a) An insurer or insurance group shall have discretion over the manner in which a CGAD is submitted, provided the CGAD shall contain the material information necessary to permit the commissioner to gain an understanding of the insurer's or insurance group's corporate governance structure, policies and practices. The commissioner may request additional information deemed material and necessary to provide the commissioner with a clear understanding of corporate governance policies and the reporting, information systems or controls used to implement those policies.

(b) Notwithstanding subsection (a) of this section, the CGAD shall be prepared consistent with this subsection and corporate governance annual disclosure regulations adopted pursuant to W.S. 26-54-104. The CGAD shall describe:

(i) The insurer's or insurance group's corporate governance framework;

(ii) The policies and practices of the most senior governing entity and significant committees thereof;

(iii) Policies and practices for directing senior management; and

(iv) The processes by which the board and senior management ensure an appropriate amount of oversight to the critical risk areas impacting the insurer’s business activities.

(c) Documentation and supporting information relevant to the CGAD shall be maintained and made available for examination or upon request of the commissioner.

26-54-106. Confidentiality.

(a) Documents, materials or other information, including the CGAD, in the possession or control of the department that are obtained by, created by or disclosed to the commissioner or any other person under this act, are recognized by this state as being proprietary and to contain trade secrets. All the documents, materials or other information shall be confidential by law and privileged, shall not be considered public records pursuant to W.S. 16-4-201 through 16-4-205, shall not be subject to subpoena and shall not be subject to discovery or admissible

as evidence in any private civil action. The commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties. The commissioner shall not otherwise make the documents, materials or other information public without the prior written consent of the insurer. Nothing in this section shall be construed to require written consent of the insurer before the commissioner may share or receive documents, materials or other information pursuant to subsection (c) of this section and as necessary to assist in the performance of the commissioner's regular duties.

(b) Neither the commissioner nor any other person who receives documents, materials or other information subject to subsection (a) of this section, through examination or otherwise, while acting under the authority of the commissioner, or with whom such documents, materials or other information are shared pursuant to this act, shall testify in any private civil action concerning the documents, materials or other information.

(c) In order to assist in the performance of the commissioner's regulatory duties, the commissioner may:

(i) Upon request, share documents, materials or other information, including confidential and privileged documents, materials or other information, which may include proprietary or trade secret information, with other state, federal and international financial regulatory agencies, including members of any supervisory college as defined under W.S. 26-44-118, with the National Association of Insurance Commissioners and with third party consultants pursuant to W.S. 26-54-107, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the documents, materials or other information and has verified in writing the legal authority to maintain confidentiality;

(ii) Receive documents, materials or other information, including confidential and privileged documents, materials or other information, which may include proprietary or trade secret information, from regulatory officials of other state, federal and international financial regulatory agencies, including members of any supervisory college as defined under W.S. 26-44-118 and from the National Association of Insurance Commissioners. The commissioner shall maintain as confidential and privileged any documents, materials or other information received under this paragraph with notice or the understanding that it is confidential and privileged under the law of the

jurisdiction that is the source of the document, materials or other information.

(d) The sharing of documents, materials or other information by the commissioner pursuant to this act shall not constitute a delegation of regulatory authority or rulemaking, and the commissioner is solely responsible for the administration, execution and enforcement of the provisions of this act.

(e) No waiver of any applicable privilege or claim of confidentiality in the documents, materials or other information shall occur as a result of disclosure of such information to the commissioner under this section or as a result of any sharing authorized by this act.

(f) Information that is disclosed in the CGAD which is also contained in any public filing or is otherwise publicly disclosed by the insurer shall not be considered privileged or confidential.

26-54-107. NAIC and third party consultants.

(a) The commissioner may retain, at the insurer's expense, third party consultants, including attorneys, actuaries, accountants and other experts not otherwise a part of the commissioner's staff, as may be reasonably necessary to assist the commissioner in reviewing the CGAD and related information submitted by an insurer or to determine an insurer’s compliance with this act.

(b) Any consultant retained under subsection (a) of this section shall act only as an independent contractor within the scope of duties established by the commissioner.

(c) The National Association of Insurance Commissioners and any person retained pursuant to subsection (a) of this section shall be subject to the same confidentiality standards and requirements as the commissioner.

(d) A third party consultant retained pursuant to subsection (a) of this section shall verify to the commissioner, with notice to the insurer, that he is free of a conflict of interest and that, if applicable, the consultant's firm has internal procedures in place to monitor compliance with a conflict and to comply with the confidentiality standards and requirements of this act.

(e) The commissioner shall enter into a written agreement with the National Association of Insurance Commissioners and any person retained pursuant to subsection (a) of this section concerning the sharing and use of information provided under this act. Consistent with W.S. 26-2-113, the agreement shall contain the following provisions and expressly require the written consent of the insurer prior to making public any information provided under this act:

(i) Specific procedures and protocols for maintaining the confidentiality and security of CGAD related information shared with the National Association of Insurance Commissioners or any person retained pursuant to subsection (a) of this section;

(ii) Procedures and protocols for the National Association of Insurance Commissioners, or other persons retained pursuant to subsection (a) of this section, to disclose CGAD related information to other state regulators from states in which an insurance group has domiciled insurers. The agreement shall provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the CGAD related documents, materials or other information and has verified in writing the legal authority to maintain confidentiality;

(iii) A provision specifying that ownership of CGAD related information shared with the National Association of Insurance Commissioners or a person retained pursuant to subsection (a) of this section remains with the department and use of the information by the National Association of Insurance Commissioners or a person retained pursuant to subsection (a) of this section is subject to the direction of the commissioner;

(iv) A provision that prohibits the National Association of Insurance Commissioners or any person retained pursuant to subsection (a) of this section from storing the information shared pursuant to this act in a permanent database after the underlying analysis is completed;

(v) A provision requiring the National Association of Insurance Commissioners or any person retained pursuant to subsection (a) of this section to provide prompt notice to the commissioner and to the insurer or insurance group upon the receipt of any subpoena, request for disclosure, or request for

production of the insurer's or insurance group's CGAD related information; and

(vi) A requirement that the National Association of Insurance Commissioners or any person retained pursuant to subsection (a) of this section shall consent to intervention by an insurer in any judicial or administrative action in which the National Association of Insurance Commissioners or the person retained pursuant to subsection (a) of this section may be required to disclose confidential information about the insurer shared with the National Association of Insurance Commissioners or a person retained pursuant to subsection (a) of this section.

26-54-108. Sanctions.

Any insurer failing, without just cause, to timely file the CGAD required by this act shall be required, after notice and hearing, to pay a penalty of one hundred dollars ($100.00) for each day that the CGAD is not filed, to be recovered by the commissioner. The maximum penalty due under this section shall be five thousand dollars ($5,000.00). The commissioner may reduce the penalty if the insurer demonstrates to the commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.

CHAPTER 55 - ENSURING TRANSPARENCY IN PRIOR AUTHORIZATION ACT

26-55-101. Short title.

This act shall be known and may be cited as the "Ensuring Transparency in Prior Authorization Act."

26-55-102. Definitions.

(a) As used in this act:

(i) "Adverse determination" means a decision by a health insurer or contracted utilization review entity to deny, reduce or terminate benefit coverage for health care services furnished or proposed to be furnished because the services are not medically necessary or are experimental or investigational. A decision to deny, reduce or terminate health care services that are not covered for reasons other than their medical necessity or experimental or investigational nature is not an "adverse determination" for purposes of this act;

(ii) "Authorization" means an approved prior authorization request;

(iii) "Chronic or long-term care condition" means a condition that lasts not less than three (3) months and requires ongoing medical attention, limits activities of daily living or both;

(iv) "Enrollee" means a person eligible to receive health care benefits by a health insurer pursuant to a health plan or other health insurance coverage. The term "enrollee" includes an enrollee's legally authorized representative;

(v) "Health care service" means health care procedures, treatments or services provided by a licensed health care facility or provided by a licensed physician or licensed health care provider. The term "health care service" also includes the provision of pharmaceutical products or services and durable medical equipment;

(vi) "Health insurer or contracted utilization review entity" means a person or entity that performs prior authorization for one (1) or more of the following entities:

(A) An employer with employees in Wyoming who are covered under a health benefit plan, disability insurance as defined by W.S. 26-5-103 or a health insurance policy;

(B) An insurer that writes health insurance policies;

(C) A preferred provider organization or health maintenance organization.

(vii) "Medically necessary health care services" means as defined by W.S. 26-40-102(a)(iii);

(viii) "Medications for opioid use disorder" means the use of medications to provide a comprehensive approach to the treatment of opioid use disorder. United States food and drug administration approved medications used to treat opioid addiction include methadone, buprenorphine, alone or in combination with naloxone, and extended-release injectable naltrexone;

(ix) "Prior authorization" means the process by which health insurers or contracted utilization review entities

determine the medical necessity or medical appropriateness of otherwise covered health care services prior to rendering such health care services. "Prior authorization" also includes any health insurer or contracted utilization review entity's requirement that an enrollee or health care provider notify the health insurer or contracted utilization review entity prior to providing a health care service;

(x) "Urgent health care service" means a health care service for which the application of the time periods for making a nonexpedited prior authorization decision could, in the opinion of a physician with knowledge of the enrollee's medical condition:

(A) Seriously jeopardize the life or health of the enrollee or the ability of the enrollee to regain maximum function; or

(B) Could subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the review. For purposes of this act, urgent health care service shall include mental and behavioral health care services.

(xi) "Step therapy protocol" means an evidence-based protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition are deemed medically appropriate for a particular patient and are covered by a health insurer or health benefit plan;

(xii) "Health care provider" means a person licensed, registered or certified under federal or state laws or regulations to provide health care services;

(xiii) "This act" means W.S. 26-55-101 through 26-55-113.

26-55-103. Disclosure and review of prior authorization requirements.

(a) Each health insurer or contracted utilization review entity shall make any current prior authorization requirements and restrictions easily accessible on its website to enrollees, health care providers and the general public. Each health insurer or contracted utilization review entity shall directly furnish those requirements and restrictions within twenty-four (24) hours after being requested by a health care provider.

Requirements and restrictions provided or posted under this subsection shall be described in detail but also in easily understandable language. Content published by a third party and licensed for use by a health insurer or contracted utilization review entity may be made available through the health insurer or contracted utilization review entity's secure password protected website, provided that the access requirements of the website do not unreasonably restrict access to any current prior authorization requirements and restrictions.

(b) Each health insurer or contracted utilization review entity shall not implement a new or amended prior authorization requirement or restriction unless its website has been updated to reflect the new or amended prior authorization requirement or restriction.

(c) Each health insurer or contracted utilization review entity shall provide affected contracted health care providers and enrollees written notice of any new or amended prior authorization requirement or restriction implemented under the health insurer's medical policy or the health insurance contract not less than sixty (60) days before the new or amended prior authorization requirement or restriction is implemented.

(d) The department of insurance shall promulgate rules requiring health insurers or contracted utilization review entities to make statistics available to the public and the department regarding prior authorizations and adverse determinations. At a minimum, the statistics shall include categories for:

(i) The health care provider specialty;

(ii) The medication or diagnostic test or procedure;

(iii) The indication offered;

(iv) The reason for the adverse determination;

(v) Whether the adverse determination was appealed;

(vi) Whether the adverse determination was upheld or reversed on appeal;

(vii) The time between submission of the prior authorization request and the authorization or initial adverse determination.

26-55-104. Persons qualified to make adverse determinations.

(a) Each health insurer or contracted utilization review entity shall ensure that all adverse determinations are made by a physician or other appropriate licensed health care provider who has:

(i) Sufficient medical knowledge in an applicable practice area or specialty;

(ii) Knowledge of the coverage criteria;

(iii) Unless otherwise required under Wyoming law, a current and unrestricted license to practice within the scope of their profession in a state, territory, commonwealth of the United States or the District of Columbia;

(iv) Knowledge of the applicable person's medical history and diagnosis.

26-55-105. Consultation after issuing an adverse determination.

After issuing an adverse determination, the health insurer or contracted utilization review entity shall provide the opportunity to the health care provider to discuss the medical necessity of the health care service with the person who has decision making authority and will be responsible for determining authorization of the health care service under review. The health insurer or contract utilization review entity shall attempt to schedule the discussion within five (5) business days after the health care provider's request.

26-55-106. Requirements applicable to persons reviewing appeals.

(a) Each health insurer or contracted utilization review entity shall ensure that all appeals of adverse determinations are reviewed by a physician or other appropriate licensed health care provider who has:

(i) Sufficient medical knowledge in an applicable practice area or specialty;

(ii) Knowledge of the coverage criteria;

(iii) A current and unrestricted license to practice within the scope of their medical profession in a state, territory, commonwealth of the United States or the District of Columbia;

(iv) Not been employed by the health insurer or contracted utilization review entity or been under contract with the health insurer or contracted utilization review entity other than to participate in one (1) or more of the health insurer or contracted utilization review entity's health care provider networks or to perform reviews of appeals, or otherwise have any financial interest in the outcome of the appeal;

(v) Not been directly involved in the initial adverse determination; and

(vi) Considered all known clinical aspects of the health care service under review, including but not limited to, a review of all pertinent medical records provided to the health insurer or contracted utilization review entity by the enrollee's health care provider, any relevant records provided to the health insurer or contracted utilization review entity by a health care facility, any pertinent material provided by the enrollee and any medical literature provided to the health insurer or contracted utilization review entity by the health care provider.

(b) The enrollee's health care provider may request upon the initiation of an appeal that the appeal from an adverse determination be made by a physician or a specialist in the area of medicine under appeal.

26-55-107. Health insurer or contracted utilization review entities' obligations regarding prior authorization for nonurgent health care services

If a health insurer or contracted utilization review entity requires prior authorization of a health care service, the health insurer or contracted utilization review entity shall make an authorization or adverse determination and notify the enrollee and the enrollee's health care provider of the authorization or adverse determination within five (5) calendar days of obtaining all necessary information to complete the review.

26-55-108. Health insurer or contracted utilization review entities' obligations with respect to prior authorizations for urgent health care services.

Each health insurer or contracted utilization review entity shall make an authorization or adverse determination concerning urgent health care services and notify the enrollee and the enrollee's health care provider of that authorization or adverse determination not later than seventy-two (72) hours after receiving all necessary information to complete the review. The prior authorization request shall be considered authorized if the health insurer or contracted utilization review entity fails to notify the enrollee and the health care provider of a decision within seventy-two (72) hours of receiving all necessary information to complete the review. A health insurer or contracted utilization review entity shall provide an online portal for health care providers to have the option of submitting urgent prior authorization requests for urgent health care services.

26-55-109. No prior authorization for medications for opioid use disorder.

No health insurer or contracted utilization review entity shall require prior authorization for the provision of medications for opioid use disorder.

26-55-110. Length of authorization generally; revocation of prior authorizations prohibited; length of authorization for chronic or long-term care conditions.

(a) Each authorization shall have the following timelines:

(i) Outpatient service prior authorizations shall be valid for a period of not less than one (1) year;

(ii) Prescription drug authorization periods shall be effective for a period of not less than one (1) year including changes in dosage for a prescription drug prescribed by a health care provider, provided that the authorization period and dosage change are consistent with dosing and duration according to evidence-based guidelines for safety and efficacy;

(iii) Prior authorizations for inpatient services shall be valid for a length of time based on the patient's clinical condition. This period will be not less than one (1) day.

(b) Each health insurer or contracted utilization review entity shall not revoke, limit, condition or restrict a previously approved authorization for health care services if the health care services are provided within forty-five (45) business days from the date the health care provider received the authorization approval for the specific service that was authorized.

(c) If a health insurer or contracted utilization review entity requires a prior authorization request for a health care service for the treatment of a chronic or long-term care condition, the authorization shall remain valid for one (1) year. This section shall not apply to the prescription of benzodiazepines or schedule II narcotic drugs.

26-55-111. Continuity of care for enrollees.

(a) On receipt of all necessary information documenting an authorization from the enrollee, previous health insurer or the enrollee's health care provider, a health insurer or contracted utilization review entity shall honor an authorization granted to an enrollee from a previous health insurer or contracted utilization review entity for not less than ninety (90) days after an enrollee's coverage under a new health plan commences, if the health care service is a covered benefit under the new health insurance plan.

(b) During the time period described in subsection (a) of this section, a health insurer or contracted utilization review entity may perform its own review to grant a new authorization.

(c) If there is a change in coverage of, or a change in approval criteria for, a previously authorized health care service under the enrollee's current health care plan, the change in coverage or approval criteria shall not affect an enrollee who received authorization less than one (1) year before the effective date of the change. A health insurer or contracted utilization review entity may require a new prior authorization request one (1) year after the enrollee's previous prior authorization was requested.

(d) No enrollee shall be required to repeat a step therapy protocol if that enrollee, while under their current or a previous health benefit plan, used the prescription drug required by the step therapy protocol, or another prescription drug in the same pharmacologic class with a similar efficacy and

side effect profile or with the same mechanism of action, and discontinued use due to lack of efficacy, effectiveness, an adverse event or contraindication. The enrollee's prescribing provider shall submit justification and clinical information, if requested, that demonstrates a clinically valid reason for why the covered prescribed drug is needed and documentation of completion of previous step therapy protocols for the prescribed drug.

26-55-112. Provider exemptions from prior authorization requirements.

(a) A health care provider, as identified by a unique national provider identifier, shall be granted a twelve (12) month or one (1) year exemption from completing a prior authorization request for a health care service, excluding the practice of pharmacy and prescription drugs, if:

(i) In the most recent twelve (12) month period, the health insurer or contracted utilization review entity has authorized not less than ninety percent (90%) of the prior authorization requests, rounded down to the nearest whole number, submitted by the health care provider for that health care service; and

(ii) The health care provider has made a prior authorization request for that health care service not less than five (5) times in the most recent twelve (12) month period.

(b) A health insurer or contracted utilization review entity may evaluate whether a health care provider continues to qualify for exemptions as described in subsection (a) of this section. Nothing in this section shall require a health insurer or contracted utilization review entity to evaluate an existing exemption under subsection (a) of this section or prevent a health insurer or contracted utilization review entity from establishing a longer exemption period.

(c) A health care provider is not required to request an exemption in order to receive an exemption under subsection (a) of this section.

(d) A health care provider who does not receive an exemption under subsection (a) of this section may request from the health insurer or contracted utilization review entity up to one (1) time per calendar year per service, evidence to support the health insurer or contracted utilization review entity's

decision. A health care provider may appeal a health insurer or contracted utilization review entity's decision to deny an exemption.

(e) A health insurer or contracted utilization review entity shall only revoke an exemption at the end of a twelve (12) month period if the health insurer or contracted utilization review entity:

(i) Makes a determination that the health care provider would not have met the ninety percent (90%), rounded down to the nearest whole number, authorization criteria based on a retrospective review of the claims for the particular service for which the exemption applies;

(ii) Provides the health care provider with the information it relied upon in making its determination to revoke the exemption; and

(iii) Provides the health care provider a plain language explanation of how to appeal the decision.

(f) An exemption under subsection (a) of this section shall remain in effect until the thirtieth day after the date the health insurer or contracted utilization review entity notifies the health care provider of its determination to revoke the exemption or, if the health care provider appeals the determination, the fifth day after the revocation is upheld on appeal.

(g) A determination to revoke or deny an exemption under subsection (a) of this section shall be made by a licensed health care provider that is of the same or similar specialty as the health care provider being considered for an exemption and has experience in providing the service for which the potential exemption applies.

(h) A health insurer or contracted utilization review entity shall provide a health care provider that receives an exemption under subsection (a) of this section a notice that includes:

(i) A statement that the health care provider qualifies for an exemption from prior authorization requirements;

(ii) A list of services for which the exemption applies; and

(iii) A statement of the twelve (12) month duration of the exemption.

(j) No health insurer or contracted utilization review entity shall deny or reduce payment for a health care service exempted from a prior authorization requirement under this section, including a health care service performed or supervised by another health care provider when the health care provider who ordered such service received a prior authorization exemption, unless the rendering health care provider:

(i) Knowingly and materially misrepresented the health care service in request for payment submitted to the health insurer or contracted utilization review entity with the specific intent to deceive and obtain an unlawful payment from the health insurer or contracted utilization review entity; or

(ii) Failed to substantially perform the health care service.

26-55-113. Prior authorization for rehabilitative or habilitative services.

(a) A health insurer or contracted utilization review entity shall not require prior authorization for rehabilitative or habilitative services including, but not limited to, physical therapy services or occupational therapy services for the first twelve (12) visits for each new episode of care. For purposes of this subsection, "new episode of care" means treatment for a new condition or treatment for a recurring condition that an enrollee has not been treated within the previous ninety (90) days.

(b) This section does not limit the right of a health insurer or contracted utilization review entity to deny a claim when an appropriate prospective or retrospective review concludes that the health care services were not medically necessary.

CHAPTER 56 - HEALTH CARE PROVIDER CREDENTIALING

26-56-101. Definitions.

(a) As used in this chapter:

(i) "Applicant" means a health care provider who submits an application to a health carrier to become credentialed as a participating health care provider in one (1) or more of the health carrier's provider networks;

(ii) "Application" means an applicant's most recent application to become credentialed by a health carrier as a participating health care provider in one (1) or more of the health carrier's provider networks;

(iii) "Completed credentialing application" means a credentialing application that is free of defects and contains all of the information that, when later supplemented by verification and documentation gathered by the health carrier during the primary source verification process, is necessary for the health carrier to make a credentialing decision;

(iv) "Credentialing" means the process by which a health carrier or its designee collects information concerning an applicant, assesses whether the applicant satisfies the requirements to become a participating health care provider in one (1) or more of the health carrier's provider networks, verifies all information submitted by the applicant and approves or denies the applicant's application;

(v) "Health carrier" means as defined by W.S. 26-13-303(a)(iii) and shall not mean pharmacy benefit managers as defined by W.S. 26-52-102(a)(vii).

26-56-102. Health care provider credentialing; requirements.

(a) Within seven (7) calendar days after a health carrier receives an application for credentialing, the health carrier shall provide the applicant notice of receipt of the application in written or electronic form and contact information for the person reviewing the application. After receiving an application, a health carrier shall determine whether the application is complete. If the health carrier determines that the application is incomplete, the health carrier shall notify the applicant in writing or by electronic means that the application is incomplete within thirty (30) calendar days after the date the health carrier received the application. The notice shall describe the items that are required to complete the application. The health care provider shall submit a completed credentialing application within thirty (30) calendar days of

receiving the notice. Failure of the health care provider to submit a completed credentialing application within thirty (30) days of receiving the notice shall restart the timelines in this subsection.

(b) A health carrier shall conclude the process of credentialing an applicant within sixty (60) calendar days after the health carrier receives the applicant's application. The sixty (60) calendar day period shall pause if a health care provider receives notification that their application is incomplete and shall resume after the health carrier verifies that the health care provider has resubmitted a completed credentialing application. A health carrier shall provide each applicant written or electronic notice of the outcome of the applicant's credentialing at the conclusion of the credentialing process.

(c) If an applicant becomes credentialed as a participating health care provider in a health carrier's network and a fully executed contract between the health care provider and the health carrier is in effect prior to covered services being provided, the health carrier shall reimburse the applicant for all covered reimbursable health care services provided by the applicant beginning with the date the health carrier received a completed credentialing application from the applicant, unless otherwise preempted by federal law.

(d) A health carrier shall not be required to approve any application for credentialing, except as provided by W.S. 26-22-503.