Mississippi Codes

TITLE 83 - INSURANCE

Chapter 5 - General Provisions Relative to Insurance and Insurance Companies.

83-5-1 - Concerns subject to department.

§ 83-5-1. Concerns subject to department.

All indemnity or guaranty companies, all companies, including those companies defined in Section 83-41-303(n), corporations, partnerships, associations, individuals and fraternal orders, whether domestic or foreign, transacting, or to be admitted to transact, the business of insurance in this state are insurance companies within the meaning of this chapter, and shall be subject to the inspection and supervision of the commissioner.

Sources: Codes, 1857, ch. 35, art. 60; 1871, § 2445; 1880, § 1076; 1892, § 2326; 1906, § 2559; Hemingway's 1917, § 5023; 1930, § 5129; 1942, § 5631; Laws, 1910, ch. 103; Laws, 1997, ch. 410, § 2, eff from and after July 1, 1997.

83-5-3 - All companies to submit to all laws of state.

§ 83-5-3. All companies to submit to all laws of state.

Every insurance company, foreign or domestic, that qualifies to do business in the State of Mississippi shall be required to execute an agreement to be bound by the statute laws of the State of Mississippi pertaining to the periods of limitation prescribed by the statute law of this state.

The insurance commissioner is hereby required, as a condition precedent to authorizing any insurance company to qualify and operate under the laws of this state or to do business in this state, to require said companies to execute an agreement binding said company to conform to and to be bound and regulated by the statute laws of this jurisdiction as defined in the first paragraph.

For purposes of the administration of this section, insurance companies shall

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consist of all types of insurance companies, both domestic and foreign, that operate in this jurisdiction, including stock companies, mutuals, and fraternal societies and organizations when such fraternal society or organization engages in the insuring of its members or other persons.

Sources: Codes, 1942, § 5631.5; Laws, 1956, ch. 343, §§ 1-4.

83-5-5 - Terms defined.

§ 83-5-5. Terms defined.

When consistent with the context and not obviously used in a different sense, the term "company" or "insurance company", as used in this chapter, includes all corporations, associations, partnerships, or individuals engaged as principals in the business of insurance or guaranteeing the obligations of others.

The word "domestic" designates those companies or other insurers incorporated or formed in this state; and the word "foreign", when used without limitation, includes all those formed by authority of any other state or government, and whose home office is not located in this state.

A contract of insurance is an agreement by which one party for a consideration promises to pay money or its equivalent, or to do some act of value to the assured, upon the destruction, loss, or injury of something in which the assured or other party has an interest, as an indemnity therefor.

Sources: Codes, 1906, §§ 2562, 2563; Hemingway's 1917, §§ 5027, 5028; 1930, §§ 5130, 5131; 1942, §§ 5632, 5633.

83-5-7 - Situs of contract.

§ 83-5-7. Situs of contract.

It shall be unlawful for any company to make any contract of insurance upon or concerning any property or interest or lives in this state, or with any resident thereof, or for any person as insurance agent or insurance broker to make, negotiate, solicit, or in any manner aid in the transaction of such insurance unless and except as authorized under the provisions of this

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chapter. All contracts of insurance on property, lives, or interests in this state shall be deemed to be made therein.

Sources: Codes, 1906, § 2563; Hemingway's 1917, § 5028; 1930, § 5131; 1942, § 5633.

83-5-9 - Business to be conducted in corporate name.

§ 83-5-9. Business to be conducted in corporate name.

Every insurance company, foreign or domestic, shall conduct its business in this state in its own proper and corporate name; and the policies and contracts of insurance issued by it shall be headed or entitled only by its proper and corporate name. When any such company publishes its assets, it shall, in the same connection and with equal conspicuousness, publish its liabilities, computed on the basis allowed for its annual statements; and any publication purporting to show its capital shall exhibit only the amount of such capital as has actually been paid in cash. Any company or any agent thereof issuing or circulating advertisements in violation of this section shall be punished by a fine of not less than fifty dollars ($50.00) nor more than two hundred dollars ($200.00).

Sources: Codes, 1880, § 1088; 1892, § 2329; 1906, § 2570; Hemingway's 1917, § 5035; 1930, § 5132; 1942, § 5634.

83-5-11 - Legal process.

§ 83-5-11. Legal process.

When legal process is served upon the commissioner as attorney for an insurance company, he shall forthwith notify the company of such service by letter prepaid and directed to its secretary or, in the case of a foreign country, to its resident manager, if any, in the United States, and shall, within two (2) days after such service, forward in the same manner a copy of the process served on him to the secretary or manager or to such person as may have been previously designated by the company by written notice filed in the office of the commissioner. The failure of the commissioner to notify the company shall not affect the validity of such service but shall subject him to liability on his bond for such damages as the company shall suffer thereby. As a condition of a valid and effectual service and of the duty of the commissioner in the premises, the plaintiff in such process shall pay to the

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commissioner at the time of service thereof the sum of Twenty-five Dollars ($25.00), which the plaintiff shall recover as taxable costs if he prevails in his suit. The commissioner shall keep a record of all such proceedings, that shall show the day and hour of service.

Sources: Codes, 1906, § 2569; Hemingway's 1917, § 5034; 1930, § 5133; 1942, § 5635; Laws, 1977, ch. 329, § 1; ch. 398, § 1; Laws, 1985, ch. 433, § 8; Laws, 1993, ch. 330, § 1; Laws, 2003, ch. 370, § 1, eff from and after July 1, 2003.

83-5-13 - Laws applicable.

§ 83-5-13. Laws applicable.

The general provisions of law relative to the powers, duties, and liabilities of corporations shall apply to all incorporated domestic insurance companies, so far as such provisions are pertinent and not in conflict with other provisions of law relative to such companies, or with their charters. All insurance companies in this state shall be governed by this chapter, anything in their special charters to the contrary notwithstanding.

Sources: Codes, 1892, § 2330; 1906, § 2571; Hemingway's 1917, § 5036; 1930, § 5134; 1942, § 5636.

83-5-15 - License fees for each class of business.

§ 83-5-15. License fees for each class of business.

No insurance company admitted to do business in the state shall be authorized to transact more than one class or kind of insurance, unless it shall pay the license fees for each class and have the requisite capital for each business engaged in. A life insurance company may do an accident business and a fire insurance company may transact insurance as prescribed in Section 83-19-1, subsections (a), (b), and (g), with the payment of the largest license fees provided for any one business done. No insurance company or other insurer shall be required to pay license fees amounting in the aggregate to more than three hundred and fifty dollars per annum.

Sources: Codes, 1906, § 2611; Hemingway's 1917, § 5074; 1930, § 5135; 1942, § 5637.

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§ 83-5-17. Revocation of license; administrative fine.

The Commissioner of Insurance may, after notice and a hearing, revoke the authority of a domestic or foreign insurance company or impose an administrative fine, or both, if it violates or neglects to comply with any provision of law obligatory on it, and whenever in the opinion of the commissioner its condition is unsound, or its assets above its liabilities, exclusive of capital and inclusive of unearned premiums, are less than the amount of its original capital or required unimpaired funds. Such administrative fine shall not exceed Five Thousand Dollars ($5,000.00) per violation and shall be deposited into the special fund in the State Treasury designated as the "Insurance Department Fund."

Sources: Codes, 1906, § 2612; Hemingway's 1917, § 5075; 1930, § 5136; 1942, § 5638; Laws, 1997, ch. 410, § 3, eff from and after July 1, 1997.

§ 83-5-19. Sale of stock regulated.

(1) No insurance company, corporation, or association of individuals shall sell or offer to sell stock in any insurance company or any insurance agency company, or permit the same to be sold or offered for sale by any firm, company, corporation, or individual to any person or persons in Mississippi until the same secures a permit or license from the insurance commissioner. Before such permit shall be granted for the sale of such stock in this state, directly or indirectly, by itself or by any firm, person, or corporation, such insurance company, corporation, or association of individuals shall file with the insurance commissioner a duly certified copy of its articles of incorporation and designate the insurance commissioner attorney for the service of legal process, as now provided by law for other insurance companies or corporations, and shall file with the insurance commissioner such other information, with reference to its proposed plans of transacting business in Mississippi, as the insurance commissioner may require. If, after an examination of such articles of incorporation, and upon being otherwise satisfied that the business proposed to be transacted in the state is proper and right under the laws of Mississippi, then the insurance commissioner shall issue the same a permit to sell its stock in the State of Mississippi.

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(2) Permit-$200 paid for examination:

Every such insurance company, corporation, or association of individuals shall pay to the insurance commissioner the sum of two hundred dollars for his services in making the examination and issuing the permit provided by the preceding subsection; and every agent, person, or corporation offering the stock for sale shall pay to the said commissioner the sum of ten dollars. Said sums shall be paid into the state treasury as other taxes collected by him. The license shall only permit such sales to be made upon plan submitted to the insurance commissioner, and at the prices and commissions designated in such license.

(3) Failure to obtain permit:

For failure or refusal to obtain authority provided for herein, such insurance company, corporation, or association of individuals so failing or refusing to obtain such permit shall be forever barred from admission to this state to transact insurance. No person, firm, or corporation shall in any manner represent, as agent or otherwise, such insurance company, corporation, or association of individuals for the sale of stock, or for any other purpose, before securing the permit herein provided.

(4) Sale of insurance and stock together prohibited:

No company, corporation, or other person within the terms of this section shall sell such stock and insurance together, or one as an inducement to the sale or purchase of the other and, for any violation of this section, shall be subject to the same penalties herein otherwise imposed for the violation of any provision of this chapter.

(5) Commissioner given power of trial justice:

For the prosecutions herein provided, the insurance commissioner shall have the powers of a trial justice, or he, or any other person cognizant of the facts, may make affidavit, returnable before a justice of the peace, whose duty it shall be to proceed with the trial as provided by law for any other violation thereof.

Sources: Codes, Hemingway's 1917, § § 5149, 5150, 5151, 5153, 5154; 1930, § 5137; 1942, § 5639; Laws, 1912, ch. 172.

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§ 83-5-21. License revoked if judgments not paid.

If a judgment shall be rendered by any court in this state against any insurance company, and such judgment shall not be paid and satisfied within ninety days after the same shall have become final, it shall be the imperative duty of the commissioner, immediately upon being advised that such judgment has not been paid or satisfied within the time named, to revoke any and every authority, license, or certificate granted to such insurance company, or any agent thereof, to transact any business in this state until again duly licensed. In case of such revocation, no renewal license or certificate of authority to transact business in this state shall be granted to such insurance company for three years after such revocation, and not then unless such judgment has been satisfied. Whenever such license shall be revoked, the commissioner shall give notice of such revocation by mail to every agent of such insurance company who shall have obtained any certificate of authority to transact business for such insurance company in this state.

Sources: Codes, 1906, § 2668; Hemingway's 1917, § 5134; 1930, § 5138; 1942, § 5640; Laws, 1912, ch. 228.

§ 83-5-23. Reserves required.

Every company transacting a fire, marine, inland, accident or casualty, surety or fidelity, or other insurance business, except life, in this state shall be required to set aside as a legal reserve to protect the holders of its policy contracts in this state the pro rata unearned portion of the premium paid for such contract, to be held until termination of such contracts, and a reserve for unpaid losses and loss adjustment expenses for incurred claims both reported and unreported. Life insurance companies shall set aside as a reserve sufficient of the premium paid each year which, if invested at four per cent interest, will pay the amount of insurance contracted for at maturity of the contract.

Sources: Codes, 1906, § 2614; Hemingway's 1917, § 5077; 1930, § 5139; 1942, § 5641; Laws, 1991, ch. 419, § 1, eff from and after July 1, 1991.

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§ 83-5-25. Certain insurance prohibited.

No life insurance company, mutual aid association, fraternal benefit society, order, or association, or stipulated premium companies operating in this state shall hereafter be permitted to issue policies, certificates, or contracts to policyholders or members providing for the establishment of its policyholders or members into divisions and classes for the purpose of providing for the payment of benefits from special funds created for such purpose to the oldest member of the division and class, or to the member of the division and class whose policy has been in force the longest period of time, upon the death of a member in such division and class, except as hereinafter provided.

Any life insurance company, mutual aid association, fraternal benefit society, order, or association, or stipulated premium companies heretofore operating on this plan in this state may continue so to do upon condition that such life insurance company, fraternal benefit society, mutual aid association, or stipulated premium companies shall not hereafter establish its policyholders or members into divisions or classes other than the divisions or classes actually containing subsisting policies or certificates on May 25, 1936.

Any life insurance company, mutual aid association, fraternal benefit society, order, or association, or stipulated premium companies violating any of the provisions of this section shall be subject to the revocation of its license to transact business in this state.

Sources: Codes, 1942, § 5642; Laws, 1936, ch. 322.

§ 83-5-27. Discrimination through fictitious grouping prohibited.

No stock, mutual, reciprocal, or other insurer shall make available to any resident or group of residents of this state, through any rating plan or form, fire, inland marine, casualty or surety insurance, or type or combination thereof, whether by master policy, series of policies, certificates of insurance, or otherwise, to any person, firm, corporation, or association of individuals, any preferred rate or premium based upon any fictitious grouping of such person, firm, corporation, or association of individuals, which

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fictitious grouping is hereby defined and declared to be any grouping by way of membership, license, franchise, agreement, or any other method or means; provided, however, that the foregoing shall not apply to life, accident, health, and hospitalization insurance.

Sources: Codes, 1942, § 5649-14; Laws, 1958, ch. 445.

83-5-28 - Cancellation, reduction in coverage, or nonrenewal of coverage; notice; inclusion in policies issued or renewed after June 30, 1989.

§ 83-5-28. Cancellation, reduction in coverage, or nonrenewal of coverage; notice; inclusion in policies issued or renewed after June 30, 1989.

(1) A cancellation, reduction in coverage or nonrenewal of liability insurance coverage, fire insurance coverage or single premium multiperil insurance coverage is not effective as to any coverage issued or renewed after June 30, 1989, unless notice is mailed or delivered to the insured and to any named creditor loss payee by the insurer not less than thirty (30) days prior to the effective date of such cancellation, reduction or nonrenewal. This section shall not apply to nonpayment of premium unless there is a named creditor loss payee, in which case at least ten (10) days' notice is required.

(2) The provisions of subsection (1) shall be incorporated into each liability, fire and multiperil policy issued or renewed after June 30, 1989; and if such provisions are not expressly stated in the policy, such provisions shall be deemed to be incorporated in the policy.

Sources: Laws, 1989, ch. 410, § 1; Laws, 2006, ch. 480, § 1, eff from and after July 1, 2006.

83-5-29 - Insurance business practices regulated.

§ 83-5-29. Insurance business practices regulated.

The purpose of Sections 83-5-29 to 83-5-51 is to regulate trade practices in the business of insurance in accordance with the intent of congress as expressed in the Act of Congress of March 9, 1945 (Public Law 15, 79th Congress), by defining, or providing for the determination of, all such practices in this state which constitute unfair methods of competition or deceptive practices, and by prohibiting the trade practices so defined or determined.

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Sources: Codes, 1942, § 5649-01; Laws, 1956, ch. 329, § 1.

83-5-30 - Notice of withdrawal, cancelation, or failure to renew insurance; penalties.

§ 83-5-30. Notice of withdrawal, cancelation, or failure to renew insurance; penalties.

Any insurer selling property and casualty insurance shall not withdraw, cancel or fail to renew any line of insurance or class of business without giving notice in writing sixty (60) days in advance to the Commissioner of Insurance. Any failure to give notice may result in a fine of up to Two Thousand Five Hundred Dollars ($2,500.00) in the discretion of the Commissioner of Insurance.

Sources: Laws, 1988, ch. 468, eff from and after July 1, 1988.

83-5-31 - Definitions.

§ 83-5-31. Definitions.

When used in Sections 83-5-29 to 83-5-51:

(a) "Person" shall mean any individual, corporation, association, partnership, reciprocal exchange, mutual, interinsurer, Lloyds insurer, fraternal benefit society, and any other legal entity engaged in the business of insurance, including agents, solicitors, brokers, and adjusters.

(b) "Commissioner" shall mean the commissioner of insurance of this state.

Sources: Codes, 1942, § 5649-02; Laws, 1956, ch. 329, § 2.

83-5-33 - Unfair methods of competition and deceptive practices prohibited.

§ 83-5-33. Unfair methods of competition and deceptive practices prohibited.

No person shall engage in this state in any trade practice which is defined in Sections 83-5-29 to 83-5-51 as, or determined pursuant to said sections to be,

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an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.

Sources: Codes, 1942, 5649-03; Laws, 1956, ch. 329, § 3.

83-5-35 - Unfair methods of competition and unfair or deceptive acts or practices defined.

§ 83-5-35. Unfair methods of competition and unfair or deceptive acts or practices defined.

The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance.

(a) Misrepresentations and false advertising of policy contracts. Making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular, or statement misrepresenting the terms of any policy issued or to be issued, or the benefits or advantages promised thereby, or the dividends or share of the surplus to be received thereon; or making any false or misleading statement as to the dividends or share of surplus previously paid on similar policies; or making 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 using any name or title of any policy or class of policies misrepresenting the true nature thereof; or making any misrepresentation to any policyholder insured in any company for the purpose of inducing or tending to induce such policyholder to lapse, forfeit, or surrender his insurance.

(b) False information and advertising generally. Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of insurance, or with respect to any person in the conduct of his insurance business, which is untrue, deceptive, or misleading.

(c) Defamation. Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any

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pamphlet, circular, article, or literature which is false and maliciously critical of or derogatory to the financial condition of an insurer, and which is calculated to injure any person engaged in the business of insurance.

(d) Boycott, coercion and intimidation. Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion, or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.

(e) False financial statements. Filing with any supervisory or other public official, or making, publishing, disseminating, circulating, or delivering to any person, or placing before the public, or causing directly or indirectly to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false statement of financial condition of an insurer, with intent to deceive.

Making any false entry in any book, report, or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to whom such insurer is required by law to report or file, or who has authority by law to examine into its condition or into any of its affairs, or, with like intent, willfully omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report, or statement of such insurer.

(f) Stock operations and insurance company advisory board contracts. Issuing or delivering, or permitting agents, officers, or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any corporation, or securities, or any special or any insurance company advisory board contracts or other contracts of any kind promising returns and profit as an inducement to insurance.

(g) Unfair discrimination. (1) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract.

(2) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever.

(h) Designation of agent, solicitor, or insurer. Requiring as a condition precedent to the purchase or the lending of money upon the security of real or

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personal property that any insurance covering such property or liability arising from the ownership, maintenance, or use thereof, to be procured by or on behalf of the vendee or by borrower in connection with such purchase or loan, be so procured through any particular person, agent, solicitor, or in any particular insurer.

This section shall not prevent the reasonable exercise by any such vendor or lender of his right to approve or disapprove the insurer selected to underwrite the insurance, and to determine the adequacy of the insurance offered.

(i) Any violation of Sections 83-3-33 and 83-3-121, Mississippi Code of 1972.

Sources: Codes, 1942, § 5649-04; Laws, 1956, ch. 329, § 4.

83-5-37 - Power of commissioner.

§ 83-5-37. Power of commissioner.

The commissioner shall have power to examine and investigate into the affairs of every person engaged in the business of insurance in this state in order to determine whether such person has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice prohibited by Section 83-5-33.

Sources: Codes, 1942, § 5649-05; Laws, 1956, ch. 329, § 5.

83-5-39 - Hearings on charges of unfair practices.

§ 83-5-39. Hearings on charges of unfair practices.

(1) Whenever the commissioner shall have reason to believe that any such person has been engaged or is engaging in this state in any unfair method of competition or any unfair or deceptive act or practice defined in Section 83-5-35, and that a proceeding by him in respect thereto would be to the interest of the public, he shall issue and serve upon such person a statement of the charges in that respect and a notice of the hearing thereon to be held at the time and place fixed in the notice, which shall not be less than ten days after the date of the service thereof.

(2) At the time and place fixed for such hearing, such person shall have an

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opportunity to be heard and to show cause why an order should not be made by the commissioner requiring such person to cease and desist from the acts, methods, or practices so complained of. Upon good cause shown, the commissioner shall permit any person to intervene, appear, and be heard at such hearing by counsel or in person.

(3) Nothing contained in Sections 83-5-29 to 83-5-51 shall require the observance at any such hearing of formal rules of pleadings or evidence.

(4) The commissioner, upon such hearing, may administer oaths, examine and cross-examine witnesses, receive oral and documentary evidence, and shall have the power to subpoena witnesses, compel their attendance, and require the production of books, papers, records, correspondence, or other documents which he deems relevant to the inquiry. The commissioner, upon such hearing, may, and upon the request of any party shall, cause to be made a stenographic record of all the evidence and all the proceedings had at such hearing. If no stenographic record is made and if a judicial review is sought, the commissioner shall prepare a statement of the evidence and proceeding for use on review. In case of a refusal of any person to comply with any subpoena issued hereunder or to testify with respect to any matter concerning which he may be lawfully interrogated, the circuit court of Hinds County, on application of the commissioner, may issue an order requiring such person to comply with such subpoena and to testify; and any failure to obey any such order of the court may be punished by the court as a contempt thereof.

(5) Statements of charges, notices, orders, and other processes of the commissioner under the cited sections may be served by anyone duly authorized by the commissioner, either in the manner provided by law for service of process in civil actions or by registering and mailing a copy thereof to the person affected by such statement, notice, order, or other process at his or its residence or principal office or place of business. The verified return by the person so serving such statement, notice, order, or other process, setting forth the manner of such service, shall be proof of the same; and the return postcard receipt for such statement, notice, order, or other process, registered and mailed as aforesaid, shall be proof of the service of the same.

Sources: Codes, 1942, § 5649-06; Laws, 1956, ch. 329, § 6.

83-5-41 - Cease and desist orders and modifications thereof; administrative fines.

§ 83-5-41. Cease and desist orders and modifications thereof; administrative fines.

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(1) If, after such hearing, the commissioner shall determine that the method of competition or the act or practice in question is defined in Section 83-5-35, and that the person complained of has engaged in such method of competition, act or practice in violation of Sections 83-5-29 through 83-5-51, he shall reduce his findings to writing and shall issue and cause to be served upon the person charged with the violation an order requiring such person to cease and desist from engaging in such method of competition, act or practice. In addition to, or in lieu of, the cease and desist order, the commissioner may, after such hearing, impose an administrative fine not to exceed Five Thousand Dollars ($5,000.00) per violation, which shall be deposited into the special fund in the State Treasury designated as the "Insurance Department Fund."

(2) Until the expiration of the time allowed under Section 83-5-43(1) for filing a petition for review (by appeal), if no such petition has been duly filed within such time or, if the petition for review has been filed within such time, then until the transcript of the record in the proceeding has been filed in the circuit court, as hereinafter provided, the commissioner may at any time, upon such notice and in such manner as he shall deem proper, modify or set aside in whole or in part any order issued by him under this section.

(3) After the expiration of the time allowed for filing such a petition for review, if no such petition has been duly filed within such time, the commissioner may, at any time after notice and opportunity for hearing, reopen and alter, modify, or set aside, in whole or in part, any order issued by him under this section whenever in his opinion conditions of fact or of law have so changed as to require such action, or if the public interest shall so require.

Sources: Codes, 1942, § 5649-07; Laws, 1956, ch. 329, § 7; Laws, 1997, ch. 410, § 4, eff from and after July 1, 1997.

83-5-43 - Judicial review of cease and desist orders.

§ 83-5-43. Judicial review of cease and desist orders.

(1) Any person required by an order of the commissioner under Section 83-5-41 to cease and desist from engaging in any unfair method of competition or any unfair or deceptive act or practice defined in Section 83-5-35 may obtain a review of such order by filing in the circuit court of Hinds County, within thirty days from the date of the service of such order, a written petition praying that the order of the commissioner be set aside. A copy of such

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petition shall be forthwith served upon the commissioner, and thereupon the commissioner forthwith shall certify and file in such court a transcript of the entire record in the proceeding, including all the evidence taken and the report and order of the commissioner. Upon such filing of the petition and transcript, such court shall have jurisdiction of the proceeding and of the question determined therein, shall determine whether the filing of such petition shall operate as a stay of such order of the commissioner, and shall have power to make and enter upon the pleadings, evidence, and proceedings set forth in such transcript a judgment modifying, affirming, or reversing the order of the commissioner, in whole or in part. The findings of the commissioner as to the facts, if supported by substantial evidence, shall be conclusive.

(2) To the extent that the order of the commissioner is affirmed, the court shall thereupon issue its own order commanding obedience to the terms of such order of the commissioner. If either party shall apply to the court for leave to adduce additional evidence, and shall show to the satisfaction of the court that such additional evidence is material and that there were reasonable grounds for the failure to adduce such evidence in the proceeding before the commissioner, the court may order such additional evidence to be taken before the commissioner and to be adduced upon the hearing in such manner and upon such terms and conditions as to the court may seem proper. The commissioner may modify his findings of fact or make new findings by reason of the additional evidence so taken; and he shall file such modified or new findings which, if supported by substantial evidence, shall be conclusive, and his recommendations, if any, for the modification or setting aside of his original order, with the return of such additional evidence.

(3) A cease and desist order issued by the commissioner under Section 83-5-41 shall become final:

(a) Upon the completion of the time allowed for filing a petition for review if no such petition has been duly filed within such time; except that the commissioner may thereafter modify or set aside his order to the extent provided in Section 83-5-41(2) or

(b) Upon the final decision of the court if the court directs that the order of the commissioner be affirmed or the petition for review dismissed.

(4) No order of the commissioner under Sections 83-5-29 to 83-5-51 or order of a court to enforce the same shall in any way relieve or absolve any person affected by such order from any liability under any other laws of this state.

Sources: Codes, 1942, § 5649-08; Laws, 1956, ch. 329, § 8.

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§ 83-5-45. Procedure as to unfair methods of competition and unfair practices which are not defined.

(1) Whenever the commissioner shall have reason to believe that any person engaged in the business of insurance is engaging in this state in any method of competition or in any act or practice in the conduct of such business which is not defined in Section 83-5-35, that such method of competition is unfair or that such act or practice is unfair or deceptive, and that a proceeding by him in respect thereto would be to the interest of the public, he may issue and serve upon such person a statement of the charges in that respect and a notice of a hearing thereon to be held at a time and place fixed in the notice, which shall not be less than ten (10) days after the date of the service thereof. Each such hearing shall be conducted in the same manner as the hearings provided in Section 83-5-39. The commissioner shall, after such hearing, make a report in writing in which he shall state his findings as to the facts, and he shall serve a copy thereof upon such person.

(2) If such report charges a violation of Sections 83-5-29 through 83-5-51, and if such method of competition, act or practice has not been discontinued, the commissioner may, through the Attorney General of this state, at any time after thirty (30) days after the service of such report, cause a petition to be filed in the circuit court of this state within the district wherein the person resides, or has his principal place of business, to enjoin and restrain such person from engaging in such method, act or practice. The court shall have jurisdiction of the proceeding and shall have power to make and enter appropriate orders in connection therewith and to issue such writs as are ancillary to its jurisdiction or are necessary in its judgment to prevent injury to the public pendente lite.

(3) A transcript of the proceedings before the commissioner, including all evidence taken and the report and findings, shall be filed with such petition. If either party shall apply to the court for leave to adduce additional evidence and shall show, to the satisfaction of the court, that such additional evidence is material and there were reasonable grounds for the failure to adduce such evidence in the proceeding before the commissioner, the court may order such additional evidence to be taken before the commissioner and to be adduced upon the hearing in such manner and upon such terms and conditions as to the court may seem proper. The commissioner may modify his findings of fact or make new findings by reason of the additional evidence so

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taken, and he shall file such modified or new findings with the return of such additional evidence.

(4) If the court finds that the method of competition complained of is unfair or that the act or practice complained of is unfair or deceptive, that the proceeding by the commissioner with respect thereto is to the interest of the public, and that the findings of the commissioner are supported by substantial evidence, it shall issue its order enjoining and restraining the continuance of such method of competition, act or practice.

(5) In addition to, or in lieu of, filing, through the Attorney General, a petition for a cease and desist order, the commissioner may, after a hearing in accordance with subsection (1), impose an administrative fine not to exceed Five Thousand Dollars ($5,000.00) per violation, which shall be deposited into the special fund in the State Treasury designated as the "Insurance Department Fund."

Sources: Codes, 1942, § 5649-09; Laws, 1956, ch. 329, § 9; Laws, 1997, ch. 410 § 5, eff from and after July 1, 1997.

83-5-47 - Judicial review by intervenor.

§ 83-5-47. Judicial review by intervenor.

If the report of the commissioner does not charge a violation of Sections 83-5-29 to 83-5-51, then any intervenor in the proceedings may, within ten days after the service of such report, cause a notice of appeal to be filed in the circuit court of Hinds County for a review of such report. Upon such review, the court shall have authority to issue appropriate orders and decrees in connection therewith, including, if the court finds that it is to the interest of the public, orders enjoining and restraining the continuance of any method of competition, act, or practice which it finds, notwithstanding such report of the commissioner, constitutes a violation of the cited sections.

Sources: Codes, 1942, § 5649-10; Laws, 1956, ch. 329, § 10.

83-5-49 - Penalty for violation of cease and desist order.

§ 83-5-49. Penalty for violation of cease and desist order.

Any person who willfully violates a cease and desist order of the commissioner

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under Section 83-5-41, after it has become final, and while such order is in effect, shall, upon proof thereof to the satisfaction of the court, forfeit and pay to the commissioner for the use of the public schools of the county or counties in which the act or acts complained of occurred, a sum to be determined by the commissioner not to exceed one thousand dollars ($1,000.00) for each violation, which if not paid may be recovered in a civil action instituted in the name of the commissioner in a court of competent jurisdiction in the county of the residence of such person who is a resident of the state. In the case of a nonresident, the action shall be brought in a court of competent jurisdiction in Hinds County.

In addition to or in lieu of the penalty set out above, the commissioner may revoke or suspend the license of such person to transact the business of insurance in this state, but from any order of the commissioner revoking or suspending such license, there shall be a right of appeal therefrom to the circuit court of the first judicial district of Hinds County in the manner provided by law.

Sources: Codes, 1942, § 5649-11; Laws, 1956, ch. 329, § 11.

83-5-51 - Provisions cumulative.

§ 83-5-51. Provisions cumulative.

Sections 83-5-29 to 83-5-51 are hereby declared to be cumulative and supplemental to all other valid statutes relating to insurance companies, agents, solicitors, and brokers, and do not repeal or amend any existing statutes.

Sources: Codes, 1942, § 5649-12; Laws, 1956, ch. 329, § 12.

83-5-53 - Blank forms furnished.

§ 83-5-53. Blank forms furnished.

It shall be the duty of the commissioner to make available upon request, at the expense of the requesting insurance company, blank forms for statements, which forms may be by him from time to time changed, as may be requisite to secure full information as to the standing, condition, and such other information desired of companies regulated by his department.

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Sources: Codes, 1906, § § 2618, 2651; Hemingway's 1917, § 5081; 1930, § § 5211, 5219; 1942, § § 5725, 5733; Laws, 2005, ch. 386, § 1, eff from and after July 1, 2005.

83-5-55 - Annual and quarterly statements to be filed.

§ 83-5-55. Annual and quarterly statements to be filed.

(1) Every insurance company shall file with the Commissioner of Insurance, on or before the first day of March of each year, a statement showing the business standing and financial condition of the company and sworn to by the president or vice president and secretary or treasurer or chief managing agent or officer of such company. The annual statement to be filed shall be in accordance with the NAIC Quarterly and Annual Statement Blank and Instructions thereto and the NAIC Accounting Practices and Procedures Manual.

(2) Every insurance company shall file with the Commissioner of Insurance a quarterly statement showing the business standing and financial condition of the company for that quarter and sworn to by the president or vice president and secretary or treasurer or chief managing agent or officer of such company. Each quarterly statement shall be filed within forty-five (45) days of the last day of the quarter. The quarterly statement to be filed shall be in accordance with the NAIC Quarterly and Annual Statement Blank and Instructions thereto and the NAIC Accounting Practices and Procedures Manual. However, the Commissioner of Insurance may grant an exemption to any domestic company transacting business in Mississippi only. No exemption shall be granted to any domestic company transacting business across state lines.

Sources: Codes, 1906, § 2619; Hemingway's 1917, § § 5082, 5083; 1930, § § 5212, 5213; 1942, § § 5726, 5727; Laws, 1916, ch. 202; Laws, 1991, ch. 550, § 1; Laws, 2001, ch. 433, § 1; Laws, 2005, ch. 386, § 2; Laws, 2007, ch. 369, § 1, eff from and after July 1, 2007.

83-5-57 - Reinsurance returns made annually.

§ 83-5-57. Reinsurance returns made annually.

Every fire insurance company now or hereafter admitted shall annually, and at such other times as the said commissioner may require, in addition to all the returns now, by law, required of it or its agents or managers, make a return

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to the insurance commissioner in such form and detail as may be prescribed by him of all reinsurance contracted for or affected by it, directly or indirectly, upon property located in Mississippi, such return to be sworn to by its president and secretary, if a company of any other state of the United States, and if a company of a foreign country by its president and secretary or by officers corresponding thereto, as to reinsurance as aforesaid contracted for or effected through the foreign office, and by the United States manager as to such reinsurance effected by the United States branch. If any company, domestic or foreign, shall directly or indirectly reinsure any risk taken by it on any property located in Mississippi in any company not duly authorized to transact business herein, except as hereinbefore provided, or if it shall refuse or neglect to make the returns required by this section, the said commissioner shall revoke its authority to transact business in this state.

Sources: Codes, 1906, § 2608; Hemingway's 1917, § 5071; 1930, § 5210; 1942, § 5724.

83-5-59 - Statements examined and abstracts published.

§ 83-5-59. Statements examined and abstracts published.

It shall be the duty of the commissioner to receive and thoroughly examine each annual statement required by this chapter and, if made in compliance with the law of Mississippi, to publish at the expense of the company an abstract of the same in one of the newspapers of the state, to be selected by the company. Such company shall, within thirty (30) days after the filing of such statement, notify the commissioner in writing of the name of the paper selected by it; otherwise, the paper shall be selected by the commissioner.

Sources: Codes, 1906, § 2620; Hemingway's 1917, § 5084; 1930, § 5214; 1942, § 5728; Laws, 1960, ch. 369, § 1.

83-5-61 - Certain premiums declared and taxed.

§ 83-5-61. Certain premiums declared and taxed.

All corporations, firms, persons, or individuals obtaining insurance on property situate in this state owned by corporations, firms, or individuals resident therein, against fire, lightning, or tornado from companies, associations, firms, or corporations not authorized to transact business in

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this state, shall file with the insurance commissioner of the state a sworn statement or declaration, setting forth the name of the company, number of policy, amount of insurance rate, premium, and description, shall be required to pay to the insurance commissioner a tax thereon of three per cent (3%) of the premiums paid on said policies, and shall further pay to said commissioner a fee of $1.00 on each policy for filing a record of the said statement or declaration, which record shall be kept for the private information of the insurance department and shall not be a public record.

Sources: Codes, 1906, § 2625; Hemingway's 1917, § 5090; 1930, § 5217; 1942, § 5731; Laws, 1912, ch. 226.

83-5-63 - Penalty for failure to declare.

§ 83-5-63. Penalty for failure to declare.

Any corporation, firm, person, or individual, resident in this state, who shall obtain or have possession of policies of insurance against loss by fire, lightning, or tornado on property situate in this state issued by companies, associations, firms, corporations, or individuals not authorized to transact the business of insurance in this state without complying with the provisions of Section 83-5-61 shall be guilty of a misdemeanor and, upon conviction thereof, shall be subject to a fine of not less than two hundred fifty nor more than one thousand dollars. Nothing herein shall prevent the placing of insurance in unauthorized companies as provided elsewhere by this chapter.

Sources: Codes, Hemingway's 1917, § 5091; 1930, § 5218; 1942, § 5732; Laws, 1912, ch. 226.

83-5-65 - Books exhibited.

§ 83-5-65. Books exhibited.

It shall be the duty of any person having in his possession or control any books, accounts, or papers of any person licensed under this chapter to exhibit the same to the commissioner on demand. On refusing to do so or knowingly or wilfully making any false statement in regard to the same, such person shall be deemed guilty of a misdemeanor and, upon conviction thereof, shall be fined or imprisoned, or both, at the discretion of the court.

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Sources: Codes, 1906, § 2622; Hemingway's 1917, § 5086; 1930, § 5215; 1942, § 5729.

83-5-67 - License revoked if statement untrue.

§ 83-5-67. License revoked if statement untrue.

If the commissioner shall become satisfied at any time that any statements made by any person licensed under this chapter shall be untrue, or in case the general agent should fail or refuse to obey the provisions of this chapter, the commissioner shall have power to revoke and cancel such license.

Sources: Codes, 1906, § 2621; Hemingway's 1917, § 5085; 1930, § 5220; 1942, § 5734.

83-5-69 - Penalty for failure to file statements and making false return.

§ 83-5-69. Penalty for failure to file statements and making false return.

Any company that neglects to make and file its quarterly and annual statement within the time provided in this chapter shall pay to the Commissioner of Insurance One Hundred Dollars ($100.00) for each day's neglect, which penalty shall be deposited into the special fund in the State Treasury designated as the "Insurance Department Fund"; and upon notice by the commissioner to that effect, its authority to do new business shall cease while such default continues. For willfully making a false annual, quarterly or other statement it is required by law to make, any insurance company, association or order, and the person making oath to or subscribing the same, shall severally be guilty of a misdemeanor; and, upon conviction, be punished by a fine of not less than Five Hundred Dollars ($500.00) nor more than One Thousand Dollars ($1,000.00). Any person making oath to such false statement shall be guilty of the crime of perjury.

Sources: Codes, 1906, § 2646; Hemingway's 1917, § 5112; 1930, § 5221; 1942, § 5735; Laws, 2002, ch. 389, § 1; Laws, 2005, ch. 386, § 3, eff from and after July 1, 2005.

83-5-71 - Duration of license.

§ 83-5-71. Duration of license.

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The licenses issued under this chapter shall continue for the next ensuing twelve (12) months after June 1 of each year unless sooner revoked or suspended by the commissioner.

Sources: Codes, 1892, § 2343; 1906, § 2624; Hemingway's 1917, § 5089; 1930, § 5216; 1942, § 5730; Laws, 1995, ch. 315, § 1, eff from and after July 1, 1995.

83-5-72 - Life, health and accident insurance companies and health maintenance organizations to contribute to Insurance Department Fund.

§ 83-5-72. Life, health and accident insurance companies and health maintenance organizations to contribute to Insurance Department Fund.

All life, health and accident insurance companies and health maintenance organizations doing business in this state shall contribute annually, at such times as the Insurance Commissioner shall determine, in proportion to their gross premiums collected within the State of Mississippi during the preceding year, to a special fund in the State Treasury to be known as the "Insurance Department Fund" to be expended by the Insurance Commissioner in the payment of the expenses of the Department of Insurance as the commissioner may deem necessary. The commissioner is hereby authorized to employ such actuarial and other assistance as shall be necessary to carry out the duties of the department; and the employees shall be under the authority and direction of the Insurance Commissioner. The amount to be contributed annually to the fund shall be fixed each year by the Insurance Commissioner at a percentage of the gross premiums so collected during the preceding year. However, a minimum assessment of One Hundred Dollars ($100.00) shall be charged each licensed life, health and accident insurance company regardless of the gross premium amount collected during the preceding year.

The total contributions collected for the Insurance Department Fund shall not exceed the sum of Seven Hundred Fifty Thousand Dollars ($750,000.00) in each fiscal year.

Sources: Laws, 1990, ch. 557, § 4; Laws, 1991, ch. 430 § 4; Laws, 1998, ch. 451, § 2, eff from and after July 1, 1998.

83-5-73 - Fees for commissioner.

§ 83-5-73. Fees for commissioner.

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The commissioner shall collect and pay into the special fund in the State Treasury designated as the "Insurance Department Fund" the following fees: for certificate of authority to each general or district agent or manager, Twenty-five Dollars ($25.00); for filing and processing an agent's certificate of authority, Twenty-five Dollars ($25.00); for filing and examining statement preliminary to admission, One Thousand Dollars ($1,000.00); for filing and processing a Form A application, Two Thousand Dollars ($2,000.00); for filing and auditing annual statement, Five Hundred Dollars ($500.00); for filing any other paper required by law, Fifty Dollars ($50.00); for continuing education courses or programs filed by the providers for approval, Fifty Dollars ($50.00); for each certification company licensed status, Forty Dollars ($40.00); for each seal when required, Twenty Dollars ($20.00); for service of process on the commissioner as attorney, Twenty-five Dollars ($25.00).

Sources: Codes, 1906, § 2630; Hemingway's 1917, § 5096; 1930, § 5222; 1942, § 5736; Laws, 1977, ch. 329, § 2; ch. 398, § 2; Laws, 1985, ch. 433, § 9; Laws, 1988, ch. 526, § 1; Laws, 1991, ch. 428 § 1; Laws, 1994, ch. 613, § 1; Laws, 2008, ch. 440, § 1, eff from and after passage (approved Apr. 7, 2008.)

83-5-75 - Fees of fraternal orders.

§ 83-5-75. Fees of fraternal orders.

For all larger fraternal orders, as defined in Section 83-30-1, the commissioner shall collect charges as provided in Section 83-5-73, as well as all other fees and charges due and payable by any company, association, order or individual in his department. If a fraternal order would not be considered a larger fraternal order under Section 83-30-1, the commissioner shall collect the following charges: for filing charter, etc., of fraternal orders doing an insurance business, preliminary to admission, Twenty-five Dollars ($25.00); for filing and auditing annual statement, Ten Dollars ($10.00); all other fees and charges due and payable by any company, association, order or individual in his department.

Sources: Codes, 1906, § 2631; Hemingway's 1917, § 5097; 1930, § 5223; 1942, § 5737; Laws, 2008, ch. 440, § 2, eff from and after passage (approved Apr. 7, 2008.)

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§ 83-5-77. Publication fees.

For publication of annual statement, there shall be a fee of Eighty Dollars ($80.00), Forty Dollars ($40.00) of which shall be paid to the publishers and Forty Dollars ($40.00) paid to the special fund in the State Treasury known as the "Insurance Department Fund". The commissioner shall receive for copy of any record or paper in his office, Fifty Cents (50) per page, and Twenty Dollars ($20.00) for certifying same, or any fact or data from the records of the office.

Sources: Codes, 1906, § 2632; Hemingway's 1917, § 5098; 1930, § 5224; 1942, § 5738; Laws, 1948, ch. 348, § 1; Laws, 1960, ch. 369, § 2; Laws, 1977, ch. 396; Laws, 1988, ch. 526, § 2; Laws, 1997, ch. 324, § 1; Laws, 2008, ch. 440, § 3, eff from and after passage (approved Apr. 7, 2008.)

§ 83-5-79. Investigation of complaint by citizens.

Complaint being filed by any citizen of this state that any company authorized to do business in this state has violated any of the provisions of the insurance laws of Mississippi, the commissioner shall diligently investigate the matter and, if necessary, examine by himself or his accredited representatives at the head office located in the United States of America such officers or agents of such company as he may deem proper; also all books, records, and papers of the same, and also the officers thereof under oath, as to such alleged violation or violations. Before making any examinations which would require the commissioner to go to a foreign state, he shall require the party or parties making complaint to file with him a good and sufficient bond to secure any expense or costs that may be necessary in making such examination. In the event that the insurance company be found not guilty of a violation of said insurance laws by the commissioner, the said bond shall be responsible for all expenses incurred by reason of such investigation; but should such company be found guilty of a violation of such laws, then said company shall be responsible for the expense thereof.

Sources: Codes, 1906, § 2655; Hemingway's 1917, § 5121; 1930, § 5201; 1942, § 5715.

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83-5-81 - Suit for payment of expense if refused.

§ 83-5-81. Suit for payment of expense if refused.

If any company shall fail or refuse to pay all legal and reasonable expenses of examination upon the presentation of a bill therefor by the commissioner, then he shall at once institute proceedings against the said company or other insurer for recovery of the same, and for this purpose may attach any of the property of the said company to be found within the jurisdiction of the court before which such proceedings are heard.

Sources: Codes, 1906, § 2656; Hemingway's 1917, § 5122; 1930, § 5202; 1942, § 5716.

83-5-83 - Refusal to comply; license revoked.

§ 83-5-83. Refusal to comply; license revoked.

If any company, corporation, or association while holding a license to transact the business of insurance in Mississippi shall fail or refuse to comply with any of the provisions or requirements of the insurance laws of this state, it shall be the duty of the commissioner of insurance to notify such company, corporation, or association by registered letter properly addressed and mailed, or by some other form of actual notice in writing delivered to an executive officer of such company, corporation, or association, of his intention to revoke the license of such company, corporation, or association to transact business in this state at the expiration of thirty days after mailing such registered letter, or a date upon which such actual notice is served. If such provisions or requirements are not fully complied with before the expiration of said thirty days, it shall be the duty of the commissioner of insurance to revoke the license of such company, corporation, or association; and in case of such revocation, such company, corporation, or association shall not be entitled to receive another license for a period of one year, and until it shall have fully complied with all such provisions and requirements of said insurance laws.

Sources: Codes, Hemingway's 1917, § 5083; 1930, § 5213; 1942, § 5727; Laws, 1916, ch. 202.

83-5-85 - General penalty.

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§ 83-5-85. General penalty.

For violation of any provisions of the insurance laws of Mississippi, the penalty whereof is not specially provided, the offender shall be guilty of a misdemeanor and, on conviction, shall be punished by a fine of not more than Five Thousand Dollars ($5,000.00). For expenses in seeking out, detecting, and punishing violations of such laws, the commissioner may assess an additional penalty to be paid by the offender as restitution in an amount to cover such expenses as may be approved by the court.

The penalties authorized by this section are cumulative and supplemental to any other penalty, fine or other sanction, and shall not be a bar to any other civil cause of action or criminal prosecution.

Sources: Codes, 1906, § 2649; Hemingway's 1917, § 5115; 1930, § 5301; 1942, § 5815; Laws, 1987, ch. 422, § 26, eff from and after January 1, 1988.

83-5-87 - Contents of residential property insurance policy.

§ 83-5-87. Contents of residential property insurance policy.

An insurance company shall not issue a residential property insurance policy that fails to include both the causes of loss of fire and extended coverages unless such policy is approved by the commissioner.

Sources: Laws, 1987, ch. 422, § 28, eff from and after January 1, 1988.

83-5-89 - Reporting arson incidents; rules and regulations.

§ 83-5-89. Reporting arson incidents; rules and regulations.

(1) The Commissioner of Insurance shall establish a program for the collection of information relating to arson incidents occurring in the state. The program shall be administered through an appropriate bureau within the Department of Insurance.

(2) The fire department, sheriff, chief of police or mayor, an agency of the state or political subdivision shall submit any information required on the

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Uniform Arson Incident Report, established by the Commissioner of Insurance, to the Commissioner of Insurance when an arson incident occurs in their respective jurisdictions.

(3) The Commissioner of Insurance shall promulgate rules to implement the program and may obtain any assistance available from the United States Department of Justice in the accomplishment of this section.

Sources: Laws, 1990, ch. 444, § 1, eff from and after July 1, 1990.

83-5-91 - Health insurance for person called to serve on active military duty by executive order of the President of the United States.

§ 83-5-91. Health insurance for person called to serve on active military duty by executive order of the President of the United States.

The Commissioner of Insurance shall issue, within thirty (30) days of March 20, 1991, a directive to every insurance carrier authorized to write health insurance policies in this state to require the following:

(a) Every insurance carrier that is providing health insurance coverage to a person at the time such person is called to serve on active military duty by Executive Order of the President of the United States, upon such person's becoming deactivated from active duty, shall resume providing the same health insurance coverage, including any preexisting condition which was covered, to that person and his or her dependents as the carrier was providing before the person was called to active military duty as provided in paragraphs (b) and (c) herein;

(b) In the case of group coverage, an employee covered under paragraph (a) of this section shall be entitled to the same coverage as the other employees of his or her group that is in effect at the time of his or her deactivation. If there is no longer a group policy in effect upon his or her deactivation, such employee shall be entitled to receive any nongroup coverage that is offered in the nongroup market by that carrier;

(c) In the case of nongroup coverage, a person covered under paragraph (a) of this section shall be entitled to receive the same coverage he or she had before serving on active military duty or if such coverage is no longer available, any other coverage offered in the nongroup market by that carrier; and

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(d) Every insurance carrier shall resume such coverage as required in this section regardless of any condition developed by the person and his or her dependents during the time the person was serving on active military duty.

Sources: Laws, 1991, ch. 404, § 1, eff from and after passage (approved March 20, 1991).

83-5-93 - Proposing party to provide impact report on legislation to enact mandated health care coverage.

§ 83-5-93. Proposing party to provide impact report on legislation to enact mandated health care coverage.

Before the Legislature's consideration of any bill that mandates health insurance coverage for specific health services, for specific diseases or for certain providers of health care services as part of any individual or group health insurance policy, the person or organization that seeks sponsorship of such proposal shall submit to the legislative committees to which the proposal is assigned an impact report that assesses the social and financial effects and the medical efficacy of the proposed mandated coverage. For purposes of Sections 83-5-93 and 83-5-95, mandated health insurance coverage shall include any legislative proposal which either mandates the inclusion of certain benefits, coverages or reimbursements for covered health care services in accident and health insurance policies or provides for the mandatory offering of such benefits, coverages or reimbursements in accident and health insurance policies.

Sources: Laws, 1993, ch. 373, § 1, eff from and after passage (approved March 15, 1993).

83-5-95 - Contents of impact report.

§ 83-5-95. Contents of impact report.

The report required under Section 83-5-93 or assessing the impact of a proposed mandate of health coverage shall include at the minimum and to the extent that information is available, the following:

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(a) The social impact, including:

(i) The extent to which the treatment or service is generally utilized by a significant portion of the population;

(ii) The extent to which such insurance coverage is already generally available;

(iii) If coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatment;

(iv) If the coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment;

(v) The level of public demand for the treatment or service;

(vi) The level of public demand for individual or group insurance coverage of the treatment or service;

(vii) The level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts; and

(viii) The impact of indirect costs which are costs other than premiums and administrative costs, on the question of the costs and benefits of coverage.

(b) The financial impact, including:

(i) The extent to which insurance coverage of the kind proposed would increase or decrease the cost of the treatment or service;

(ii) The extent to which the proposed coverage might increase the use of the treatment or service;

(iii) The extent to which the mandated treatment or service might serve as an alternative for more expensive treatment or service;

(iv) The extent to which insurance coverage of the health care service or provider can be reasonably expected to increase or decrease the insurance premium and administrative expenses of policyholders; and

(v) The impact of this coverage on the total cost of health care.

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(c) The medical efficacy, including:

(i) The contribution of the insurance coverage to the quality of patient care and the health status of the population, including the results of any research demonstrating the medical efficacy of the treatment or service compared to alternatives or not providing the treatment or service; and

(ii) If the legislation seeks to mandate coverage of an additional class of practitioners:

1. The results of any professionally acceptable research demonstrating the medical results achieved by the additional class of practitioners relative to those already covered; and

2. The methods of the appropriate professional organization that assure clinical proficiency.

(d) The effects of balancing the social, economic and medical efficacy considerations, including:

(i) The extent to which the need for coverage outweighs the cost of mandating the benefit for all insureds; and

(ii) The extent to which the problem of coverage may be solved by mandating the availability of the coverage as an option for insureds.

Sources: Laws, 1993, ch. 373, § 2, eff from and after passage (approved March 15, 1993).

83-5-101 - Audited financial report.

§ 83-5-101. Audited financial report.

All insurers shall have an annual audit by an independent certified public accountant and shall file an audited financial report as a supplement to the annual statement on or before June 1 for the year ended December 31 immediately preceding. The Commissioner of Insurance may require an insurer to file an audited financial report earlier than June 1 with ninety (90) days' advance notice to the insurer.

Sources: Laws, 1991, ch. 550, § 2, eff from and after July 1, 1991.

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§ 83-5-102. Definitions.

[Effective until January 1, 2010, this section will read:].

As used in Sections 83-5-102 through 83-5-113, the following terms have the respective meanings herein set forth unless the context shall require otherwise:

(a) "Audited financial report" means and includes those items specified in Section 83-5-103.

(b) "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.

(c) "Commissioner" means the Commissioner of Insurance.

(d) "Department" means the Department of Insurance.

(e) "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.

(f) "Insurer" means a licensed insurer as defined in Section 83-5-1.

[Effective from and after January 1, 2010, this section will read:].

As used in Sections 83-5-102 through 83-5-113, the following terms have the respective meanings herein set forth unless the context shall require otherwise:

(a) "Audited financial report" means and includes those items specified in Section 83-5-103.

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(b) "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, it means a Canadian chartered or British chartered accountant.

(c) "Commissioner" means the Commissioner of Insurance.

(d) "Department" means the Department of Insurance.

(e) "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.

(f) "Insurer" means an insurer as defined in Section 83-5-1.

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

(h) "Audit committee" means a committee (or equivalent body) 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, and 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 or more of these controlled insurers solely for the purposes of this section at the election of the controlling person. Refer to Section 83-5-119(e) for exercising this election. If an audit committee is not designated by the insurer, the insurer's entire board of directors shall constitute the audit committee.

(i) "Independent board member" has the same meaning as described in Section 83-5-119(c).

(j) "Group of insurers" means those licensed insurers included in the reporting requirements of Sections 83-6-1 through 83-6-43, or a set of insurers as identified by management, for the purpose of assessing the effectiveness of internal control over financial reporting.

(k) "Internal control over financial reporting" means a process effected by an entity's board of directors, management and other personnel designed to

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provide reasonable assurance regarding the reliability of the financial statements and includes those policies and procedures that:

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

(ii) 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

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

(l) "RBC" means risk-based capital pursuant to Sections 83-5-401 through 83-5-427.

(m) "SEC" means the United States Securities and Exchange Commission.

(n) "Section 404" means Section 404 of the Sarbanes-Oxley Act of 2002 and the SEC's rules and regulations promulgated thereunder.

(o) "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.

(p) "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: (i) the preapproval requirements of Section 201 (Section 10A(i) of the Securities Exchange Act of 1934); (ii) the audit committee independence requirements of Section 301 (Section 10A(m)(3) of the Securities Exchange Act of 1934); and (iii) the internal control over financial reporting requirements of Section 404 (Item 308 of SEC Regulation S-K).

Sources: Laws, 1991, ch. 550, § 3; Laws, 2007, ch. 369, § 2; Laws, 2009, ch. 334, § 1, eff from and after Jan. 1, 2010.

83-5-103 - Content of annual audited financial report.

§ 83-5-103. Content of annual audited financial report.

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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 the year then ended in conformity with statutory accounting practices prescribed, or otherwise permitted, by the Department of Insurance of the state of domicile.

The annual audited financial report shall include the following:

(a) Report of independent certified public accountant.

(b) Balance sheet reporting admitted assets, liabilities, capital and surplus.

(c) Statement of operations.

(d) Statement of cash flows.

(e) Statement of changes in capital and surplus.

(f) Notes to financial statements. These notes shall be those required by the appropriate NAIC Annual Statement Instructions and the NAIC Accounting Practices and Procedures Manual. The notes shall include a reconciliation of differences, if any, between the audited statutory financial statements and the annual statement filed pursuant to Section 83-5-55 with a written description of the nature of these differences.

(g) 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, and the financial statements shall be comparative, presenting the amounts as of December 31 of the current year and the amounts as of the immediately preceding December 31. However, in the first year in which an insurer is required to file an audited financial report, the comparative data may be omitted.

Sources: Laws, 1991, ch. 550, § 4; Laws, 2007, ch. 369, § 3, eff from and after July 1, 2007.

83-5-104 - Exemptions.

§ 83-5-104. Exemptions.

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[Effective until January 1, 2010, this section will read:]

Every insurer shall be subject to Sections 83-5-101 through 83-5-113. Insurers having direct premiums written 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 directly written policies nationwide at the end of such calendar year shall be exempt from Sections 83-5-101 through 83-5-113 for such year unless the commissioner makes a specific finding that compliance is necessary for the commissioner to carry out statutory responsibilities, except that insurers having assumed premiums pursuant to contracts and/or treaties of reinsurance of One Million Dollars ($1,000,000.00) or more will not be so exempt.

Upon written application of any insurer, the commissioner may grant an exemption from compliance with Sections 83-5-101 through 83-5-113 if the commissioner finds, upon review of the application, that compliance with Sections 83-5-101 through 83-5-113 would constitute a financial or organizational hardship upon the insurer. An exemption may be granted at any time and from time to time for a specified period or periods. Within ten (10) days from a denial of an insurer's written request for an exemption from Sections 83-5-101 through 83-5-113, such insurer may request in writing a hearing on its application for an exemption. Such hearing shall be held in accordance with the rules and regulations of the Department of Insurance pertaining to administrative hearing procedures.

Insurers not retaining a certified public accountant as required in Sections 83-5-101 through 83-5-113 who qualify as independent may meet the following schedule for compliance unless the Commissioner of Insurance permits otherwise:

(a) As of December 31, 1991, file with the Commissioner of Insurance:

(i) Report of independent certified public accountant;

(ii) Audited balance sheet;

(iii) Notes to audited balance sheet.

(b) For the year ending December 31, 1992, and each year thereafter, such insurers shall file all reports required by Sections 83-5-101 through 83-5-

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113.

[Effective from and after January 1, 2010, this section will read:]

Every insurer shall be subject to Sections 83-5-101 through 83-5-113. Insurers having direct premiums written 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 directly written policies nationwide at the end of such calendar year shall be exempt from Sections 83-5-101 through 83-5-113 for such year unless the commissioner makes a specific finding that compliance is necessary for the commissioner to carry out statutory responsibilities, except that insurers having assumed premiums pursuant to contracts and/or treaties of reinsurance of One Million Dollars ($1,000,000.00) or more will not be so exempt.

Upon written application of any insurer, the commissioner may grant an exemption from compliance with Sections 83-5-101 through 83-5-113 if the commissioner finds, upon review of the application, that compliance with Sections 83-5-101 through 83-5-113 would constitute a financial or organizational hardship upon the insurer. An exemption may be granted at any time and from time to time for a specified period or periods. Within ten (10) days from a denial of an insurer's written request for an exemption from Sections 83-5-101 through 83-5-113, such insurer may request in writing a hearing on its application for an exemption. Such hearing shall be held in accordance with the rules and regulations of the Department of Insurance pertaining to administrative hearing procedures.

Sources: Laws, 1991, ch. 550, § 5; Laws, 2009, ch. 334, § 2, eff from and after Jan. 1, 2010.

83-5-105 - Extensions.

§ 83-5-105. Extensions.

[Effective until January 1, 2010, this section will read:]

Extensions of the June 1 filing date may be granted by the commissioner for thirty-day periods upon showing by the insurer and its independent certified public accountant the reasons for requesting such extension and determination

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by the commissioner of good cause for an extension. The request for extension must 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.

[Effective from and after January 1, 2010, this section will read:]

Extensions of the June 1 filing date may be granted by the commissioner for thirty-day periods upon showing by the insurer and its independent certified public accountant the reasons for requesting such extension and determination by the commissioner of good cause for an extension. The request for extension must 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.

If an extension is granted, a similar extension of thirty (30) days is granted to the filing of Management's Report of Internal Control over Financial Reporting.

Sources: Laws, 1991, ch. 550, § 6; Laws, 2009, ch. 334, § 3, eff from and after Jan. 1, 2010.

83-5-106 - Designation of independent certified public accountants.

§ 83-5-106. Designation of independent certified public accountants.

Each insurer required to file an annual audited financial report must, within sixty (60) days after becoming subject to such requirement, register with the commissioner in writing the name and address of the independent certified public accountant or accounting firm (generally referred to here as the "accountant") retained to conduct the annual audit set forth in Section 83-5-101. Insurers not previously retaining an independent certified public accountant shall register the name and address of their retained certified public accountant not less than six (6) months before the date when the first audited financial report is to be filed.

The insurer shall obtain a letter from such 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 Department of Insurance

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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 the department, specifying such exceptions as he may believe appropriate.

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 Insurance 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 such event 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 disagreements, 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 in response to this section include both those resolved to the former accountant's satisfaction and those not resolved to the former accountant's satisfaction. Disagreements contemplated by this section are those that occur at the decision-making level, i.e., 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 such former accountant to furnish a letter addressed 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; and the insurer shall furnish such responsive letter from the former accountant to the commissioner together with its own.

Sources: Laws, 1991, ch. 550, § 7, eff from and after July 1, 1991.

83-5-107 - Qualifications of independent certified public accountant.

§ 83-5-107. Qualifications of independent certified public accountant.

[Effective until January 1, 2010, this section will read:]

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

(a) Is not in good standing with the American Institute of Certified Public

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Accountants and in all states in which the accountant is licensed to practice, or for a Canadian company, that is not a chartered account; or

(b) Has either directly or indirectly entered into an agreement of indemnity or release from liability, collectively referred to as indemnification, with respect to the audit of the insurer.

(2) Except as otherwise provided herein, the commissioner shall recognize an independent certified public accountant as qualified as long as he or she conforms to the standards of his or her 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 appropriate state board of public accountancy, or similar code.

(3) 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 Sections 83-23-1 through 83-23-9, the mediation or arbitration provisions shall operate at the option of the statutory successor.

(4) No partner or other person responsible for rendering a report may act in that capacity for more than seven (7) consecutive years. Following any period of service such 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 two (2) years. An insurer may make application to the commissioner for relief from the above rotation requirement on the basis of unusual circumstances. The commissioner may consider the following factors in determining if the relief should be granted: (a) number of partners, expertise of the partners or the number of insurance clients in the currently registered firm; (b) premium volume of the insurer; or (c) number of jurisdictions in which the insurer transacts business.

(5) The commissioner shall not 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 (a) has been convicted of fraud, bribery, a violation of the Racketeer Influenced and Corrupt Organizations Act, 18 USCS Sections 1961-1968, or any dishonest conduct or practices under federal or state law; (b) has been found to have violated the insurance laws of this state with respect to any previous reports submitted under this rule; or (c) has demonstrated a pattern or practice of failing to detect or disclose material information in previous reports filed under the provisions of Sections 83-5-101 through 83-5-113.

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(6) The commissioner may hold a hearing to determine whether a 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 Sections 83-5-101 through 83-5-113 and require the insurer to replace the accountant with another whose relationship with the insurer is qualified within the meaning of this section.

[Effective from and after January 1, 2010, this section will read:]

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

(a) 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

(b) Has either directly or indirectly entered into an agreement of indemnity or release from liability, collectively referred to as indemnification, with respect to the audit of the insurer.

(2) Except as otherwise provided herein, the commissioner shall recognize an independent certified public accountant as qualified as long as he or she conforms to the standards of his or her 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 appropriate state board of public accountancy, or similar code.

(3) 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 Sections 83-23-1 through 83-23-9, the mediation or arbitration provisions shall operate at the option of the statutory successor.

(4) The lead or coordinating audit partner having primary responsibility for the audit may 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 above rotation requirement on the basis of unusual circumstances. This application should be made at least thirty (30)

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days before the end of the calendar year. The commissioner may consider the following factors in determining if the relief should be granted:

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

(b) Premium volume of the insurer; or

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

The insurer shall file, with its annual statement filing, the approval for relief with the states that it is licensed or doing business.

(5) 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, a natural person who:

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

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

(c) Has demonstrated a pattern or practice of failing to detect or disclose material information in previous reports filed under the provisions of Sections 83-5-101 through 83-5-113.

(6) 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 Sections 83-5-101 through 83-5-113 and require the insurer to replace the accountant with another whose relationship with the insurer is qualified within the meaning of this section.

(7) The commissioner shall not 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:

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

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(b) Financial information systems design and implementation;

(c) Appraisal or valuation services, fairness opinions, or contribution-in-kind reports;

(d) 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 ("opinion") on an insurer's reserves if the following conditions have been met:

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

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

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

(e) Internal audit outsourcing services;

(f) Management functions or human resources;

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

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

(i) Any other services that the commissioner determines are impermissible.

In general, the principles of independence with respect to services provided by the qualified independent certified public accountant are largely predicated on three (3) basic principles, violations of which would impair the accountant's independence. The principles are that the accountant cannot function in the role of management, cannot audit his or her own work, and cannot serve in an advocacy role for the insurer.

(8) A qualified independent certified public accountant who performs the audit may engage in other nonaudit services, including tax services, that are not

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described in subsection (7) or that do not conflict with subsection (7), only if the activity is approved in advance by the audit committee, in accordance with subsection (9).

(9) 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 is 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:

(a) The aggregate amount of all such 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;

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

(c) 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 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.

(10) The audit committee may delegate to one or more designated members of the audit committee the authority to grant the preapprovals required by subsection (9). 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.

(11) 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-year period preceding the date that the most current statutory opinion is due. This section shall only apply to partners and senior managers involved in the audit. An insurer may make application to the commissioner for relief from the above requirement on the basis of unusual circumstances.

The insurer shall file, with its annual statement filing, the approval for relief with the states that it is licensed or doing business.

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Sources: Laws, 1991, ch. 550, § 8; Laws, 2003, ch. 420, § 1; Laws, 2007, ch. 369, § 4; Laws, 2009, ch. 334, § 4, eff from and after Jan. 1, 2010.

83-5-108 - Consolidated or combined audits.

§ 83-5-108. Consolidated or combined audits.

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 such insurer cedes all of its direct and assumed business to the pool. In such cases, a columnar consolidating or combining work sheet shall be filed with the report, as follows:

(a) Amounts shown on the consolidated or combined audited financial report shall be shown on the work sheet.

(b) Amounts for each insurer subject to this section shall be stated separately.

(c) Noninsurance operations may be shown on the work sheet on a combined or individual basis.

(d) Explanations of consolidating and eliminating entries shall be included.

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

Sources: Laws, 1991, ch. 550, § 9, eff from and after July 1, 1991.

83-5-109 - Scope of examination and report of independent certified public accountant.

§ 83-5-109. Scope of examination and report of independent certified public accountant.

[Effective until January 1, 2010, this section will read:]

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Financial statements furnished pursuant to Section 83-5-103 shall be examined by an independent certified public accountant. The examination of the insurer's financial statements shall be conducted in accordance with generally accepted auditing standards. Consideration should also be given to such other procedures illustrated in the Financial Condition Examiners Handbook promulgated by the National Association of Insurance Commissioners as the independent certified public accountant deems necessary.

[Effective from and after January 1, 2010, this section will read:]

Financial statements furnished pursuant to Section 83-5-103 shall be audited by an independent certified public accountant. The audit of the insurer's financial statements shall be conducted in accordance with generally accepted auditing standards. The independent certified public accountant should obtain an understanding of internal control sufficient to plan the audit. To the extent required by generally accepted auditing standards, for those insurers required to file a Management's Report of Internal Control over Financial Reporting pursuant to Section 83-5-123, the independent certified public accountant should consider (as that term is defined in Statement on Auditing Standards No. 102, "Defining Professional Requirements in Statements on Auditing Standards," or its replacement) 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 Examiners Handbook promulgated by the National Association of Insurance Commissioners as the independent certified public accountant deems necessary.

Sources: Laws, 1991, ch. 550, § 10; Laws, 2009, ch. 334, § 5, eff from and after Jan. 1, 2010.

83-5-110 - Notification of adverse financial condition.

§ 83-5-110. Notification of adverse financial condition.

The insurer required to furnish the 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 reasonable belief by the independent certified public accountant that the insurer has materially misstated its financial condition as reported to the commissioner as of the balance sheet date currently under examination or that

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the insurer does not meet the minimum capital and surplus requirement of the state insurance laws as of that date. An insurer who has received a report pursuant to this paragraph shall forward a copy of the report to the commissioner within five (5) business days of receipt of such report and shall provide the independent certified public accountant making the report with evidence of the report being furnished to the commissioner. If the independent certified public accountant fails to receive such evidence within the required five (5) business days period, the independent certified public accountant shall furnish to the commissioner a copy of its report within the next five (5) business days.

No independent public accountant shall be liable in any manner to any person for any statement made in connection with the above paragraph if such statement is made in good faith in compliance with the above paragraph.

If the accountant, subsequent to the date of the audited financial report filed pursuant to Sections 83-5-101 through 83-5-113, becomes aware of facts which might have affected his report, the accountant is obligated to take such action as prescribed in Volume I, Section AU 561 of the Professional Standards of the American Institute of Certified Public Accountants.

Sources: Laws, 1991, ch. 550, § 11, eff from and after July 1, 1991.

83-5-111 - Report on significant deficiencies in internal controls.

§ 83-5-111. Report on significant deficiencies in internal controls.

[Effective until January 1, 2010, this section will read:]

In addition to the annual audited financial statements, each insurer shall furnish the commissioner with a written report prepared by the accountant describing significant deficiencies in the insurer's internal control structure noted by the accountant during the audit. SAS No. 60, Communication of Internal Control Structure Matters Noted in an Audit (AU Section 325 of the Professional Standards of the American Institute of Certified Public Accountants) requires an accountant to communicate significant deficiencies (known as "reportable conditions") noted during a financial statement audit to the appropriate parties within an entity. No report should be issued if the accountant does not identify significant deficiencies. If significant

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deficiencies are noted, the written report shall be filed annually by the insurer with the department within sixty (60) days after the filing of the annual audited financial statements. The insurer is required to provide a description of remedial actions taken or proposed to correct significant deficiencies if such actions are not described in the accountant's report.

[Effective from and after January 1, 2010, this section will read:]

In addition to the annual audited financial report, each insurer shall furnish the commissioner with a written communication as to any unremediated material weaknesses in its internal control over financial reporting noted 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 the term material weakness is defined by Statement on Auditing Standard No. 115, "Communication of Internal Control Related Matters Identified in an Audit," or its replacement) as of December 31 immediately preceding in the insurer's internal control over financial reporting noted by the accountant during the course of their audit of the financial statements. If no unremediated material weaknesses were noted, the communication should so state.

The insurer is required to 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.

Sources: Laws, 1991, ch. 550, § 12; Laws, 2009, ch. 334, § 6, eff from and after Jan. 1, 2010.

83-5-112 - Accountant's letter of qualifications.

§ 83-5-112. Accountant's letter of qualifications.

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

(a) That he 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 appropriate state board of public

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accountancy, or similar code.

(b) 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 section shall be construed as prohibiting the accountant from utilizing such staff as he deems appropriate where such use is consistent with the standards prescribed by generally accepted auditing standards.

(c) That the accountant understands the annual audited financial report and his opinion thereon will be filed in compliance with this section and that the commissioner will be relying on this information in the monitoring and regulating of the financial position of insurers.

(d) That the accountant consents to the requirements of Section 83-5-113 and that the accountant consents and agrees to make available for review by the commissioner, his designee or his appointed agent, the work papers, as defined in Section 83-5-113.

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

(f) A representation that the accountant is in compliance with the requirements of Section 83-5-107.

Sources: Laws, 1991, ch. 550, § 13, eff from and after July 1, 1991.

83-5-113 - Accountant's letter of qualifications.

§ 83-5-113. Accountant's letter of qualifications.

[Effective until January 1, 2010, this section will read:]

Work papers are the records kept by the independent certified public accountant of the procedures followed, the tests performed, the information obtained and the conclusion reached pertinent to his examination of the financial statements of an insurer. Work papers, accordingly, 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

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accountant in the course of his examination of the financial statements of an insurer and which support his opinion thereof.

Every insurer required to file an audited financial report pursuant to Sections 83-5-101 through 83-5-113 shall require the accountant to make available for review by department examiners all work papers prepared in the conduct of his examination and any communications related to the audit between the accountant and the insurer, at the offices of the insurer, at the Department of Insurance or at any other reasonable place designated by the commissioner. The insurer shall require that the accountant retain the audit work papers and communications until the Department of Insurance has filed a report on examination covering the period of the audit.

In the conduct of the aforementioned periodic review by the department examiners, it shall be agreed that photocopies of pertinent audit work papers may be made and retained by the department. Such reviews by the department examiners shall be considered investigations and all work papers and communications obtained during the course of such investigations shall be afforded the same confidentiality as other examination work papers generated by the department.

[Effective from and after January 1, 2010, this section will read:]

Work papers are the records kept by the independent certified public accountant of the procedures followed, the tests performed, the information obtained and the conclusion reached pertinent to his examination of the financial statements of an insurer. Work papers, accordingly, 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 examination of the financial statements of an insurer and which support his opinion thereof.

Every insurer required to file an audited financial report pursuant to Sections 83-5-101 through 83-5-113 shall require the accountant to make available for review by department examiners all work papers prepared in the conduct of his examination and any communications related to the audit between the accountant and the insurer, at the offices of the insurer, at the Department of Insurance or at any other reasonable place designated by the commissioner. The insurer shall require that the accountant retain the audit

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work papers and communications until the Department of Insurance 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.

In the conduct of the aforementioned periodic review by the department examiners, it shall be agreed that photocopies of pertinent audit work papers may be made and retained by the department. Such reviews by the department examiners shall be considered investigations and all work papers and communications obtained during the course of such investigations shall be afforded the same confidentiality as other examination work papers generated by the department.

Sources: Laws, 1991, ch. 550, § 13; Laws, 2009, ch. 334, § 7, eff from and after Jan. 1, 2010.

83-5-114 - Severability [Effective January 1, 2010].

§ 83-5-114. Severability [Effective January 1, 2010].

If any section or portion of a section of Sections 83-5-101 through 83-5-113 or its applicability to any person or circumstance is held invalid by a court, the remainder of this chapter or the applicability of the provision to other persons or circumstances shall not be affected.

Sources: Laws, 2009, ch. 334, § 12, eff from and after Jan. 1, 2010.

83-5-115 - Authority of Department of Insurance to determine method of calculating values of stocks, bonds and other sureties held by insurer.

§ 83-5-115. Authority of Department of Insurance to determine method of calculating values of stocks, bonds and other sureties held by insurer.

(1) All bonds or other evidences of debt having a fixed term and rate of interest held by an insurer, if secured and not in default as to principal or interest, may be valued as follows:

(a) If purchased at par, at the par value.

(b) If purchased above or below par, on the basis of the purchase price

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adjusted to bring the value to par at maturity and to yield in the meantime the effective rate of interest at which the purchase was made, or in lieu of this method, according to any accepted method of valuation approved by the Department of Insurance.

(c) Purchase price shall not be taken at a higher figure than the actual market value at the time of purchase, plus actual brokerage, transfer, postage or express charges paid in the acquisition of the securities.

(2) The Department of Insurance shall have full discretion in determining the method of calculating values according to the rules set forth in this section, but no method or valuation shall be inconsistent with any applicable valuation or method used by insurers in general or any method formulated or approved by the National Association of Insurance Commissioners or its successor organization.

Sources: Laws, 1994, ch. 313, § 1, eff from and after July 1, 1994.

83-5-117 - Methods of valuation which may be used to calculate values of stocks, bonds and other sureties held by insurer.

§ 83-5-117. Methods of valuation which may be used to calculate values of stocks, bonds and other sureties held by insurer.

(1) Securities, other than those referred to in 83-5-115, held by an insurer shall be valued, in the discretion of the Department of Insurance, at their market value or at their appraised value or at prices determined by it as representing their fair market value.

(2) Preferred or guaranteed stocks or shares while paying full dividends may be carried at a fixed value in lieu of market value, at the discretion of the Department of Insurance and in accordance with the method of valuation as it may approve.

(3) Stock of a subsidiary corporation of an insurer shall not be valued at an amount in excess of the net value thereof as based upon those assets only of the subsidiary which would be eligible under either Section 83-6-2 or 83-19-51 for investment of the funds of the insurer directly.

(4) No valuations under this section shall be inconsistent with any applicable valuation or method formulated or approved by the National Association of Insurance Commissioners or its successor organization.

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Sources: Laws, 1994, ch. 313, § 2, eff from and after July 1, 1994.

83-5-119 - Requirements for audit committees [Effective January 1, 2010].

§ 83-5-119. Requirements for audit committees [Effective January 1, 2010].

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 section at the election of the controlling person.

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.

(a) The 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) for the purpose of preparing or issuing the audited financial report or related work pursuant to this section. Each accountant shall report directly to the audit committee.

(b) 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 paragraph (e) and Section 83-5-102(h).

(c) In order to be considered independent for purposes of this section, a member of the audit committee may not, other than in his or her 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. However, if law requires board participation by otherwise nonindependent members, that law shall prevail and such 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 of its affiliates.

(d) 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

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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.

(e) To exercise the election of the controlling person to designate the audit committee for purposes of this section, 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 can 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.

(f) (i) The audit committee shall require the accountant that performs for an insurer any audit required by this section to timely report to the audit committee in accordance with the requirements of Statement on Auditing Standard No. 114, The Auditor's Communication With Those Charged With Governance or its replacement, including:

1. All significant accounting policies and material permitted practices;

2. 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

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

(ii) If an insurer is a member of an insurance holding company system, the reports required by paragraph (f)(i) 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.

(g) The proportion of independent audit committee members shall meet or exceed the following criteria:

Prior Calendar Year Direct Written and Assumed Premiums

$0-$300,000,000 over $300,000,000- Over $500,000,000

$500,000,000

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No minimum Majority (50% or more) Supermajority of

requirments. See of members shall be members (75% or

also Note A and B. independent. See more) shall be

also Note A and B. independent. See

also Note A.

Note A: 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 a RBC action level event, meets one or more of the standards of an insurer deemed to be in hazardous financial condition, or otherwise exhibits qualities of a troubled insurer.

Note B: All insurers with less than Five Hundred Million Dollars ($500,000,000.00) in prior year direct written and assumed premiums are encouraged to structure their audit committees with at least a supermajority of independent audit committee members.

Note C: 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.

(h) An insurer with direct written and assumed premium, 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 upon hardship. The insurer shall file, with its annual statement filing, the approval for relief from the requirements of this section with the states that it is licensed or doing business.

(i) 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 (as opposed to a supermajority) because the total written and assumed premium is below the threshold and subsequently becomes subject to one (1) of the independence requirements due to changes in premium shall have one (1) year following the year the threshold is exceeded to comply with the independence requirements. Likewise, an insurer that becomes subject to one

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(1) 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.

Sources: Laws, 2009, ch. 334, § 8, eff from and after Jan. 1, 2010.

83-5-121 - Conduct of insurer in connection with the preparation of required reports and documents [Effective January 1, 2010].

§ 83-5-121. Conduct of insurer in connection with the preparation of required reports and documents [Effective January 1, 2010].

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

(a) 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 section; or

(b) 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 section.

(2) 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 section if that person knew or should have known that the action, if successful, could result in rendering the insurer's financial statements materially misleading.

(3) For purposes of subsection (2) of this section, 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:

(a) To 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);

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

(c) Not to withdraw an issued report; or

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

Sources: Laws, 2009, ch. 334, § 9, eff from and after Jan. 1, 2010.

83-5-123 - Management's report of internal control over financial reporting [Effective January 1, 2010].

§ 83-5-123. Management's report of internal control over financial reporting [Effective January 1, 2010].

(1) Every insurer required to file an audited financial report pursuant to this section 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, as these terms are defined in Section 83-5-102. The report shall be filed with the commissioner along with the Communication of Internal Control Related Matters Noted in an Audit described under Section 83-5-111. Management's Report of Internal Control over Financial Reporting shall be as of December 31 immediately preceding. Foreign or alien insurers required to file Management's Report of Internal Control over Financial Reporting in another state are exempt from filing the Management's Report of Internal Control over Financial Reporting in this state provided the other state has substantially similar reporting requirements and the Management's Report of Internal Control over Financial Reporting is filed with the commissioner of the other state within the time specified. An insurer or group of insurers that is not required to file Management's Report of Internal Control over Financial Reporting 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. Likewise, an insurer acquired in a business combination shall have two (2) calendar years following the date of acquisition or combination to comply with the reporting requirements.

(2) Notwithstanding the premium threshold in subsection (1), 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

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or more of the standards of an insurer deemed to be in hazardous financial condition as defined by regulation.

(3) An insurer or a group of insurers that is:

(a) Directly subject to Section 404;

(b) Part of a holding company system whose parent is directly subject to Section 404;

(c) Not directly subject to Section 404 but is a SOX Compliant Entity; or

(d) 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 the requirements of this section provided that those internal controls of the insurer or group of insurers having a 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 statutory 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 (i) a report required pursuant to this section, or (ii) the Section 404 Report and a report required pursuant to 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.

(4) Management's Report of Internal Control over Financial Reporting shall include:

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

(b) 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

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principles;

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

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

(e) Disclosure of any unremediated material weaknesses in the internal control over financial reporting identified by management as of December 31 immediately preceding. Management is not permitted to 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 or more unremediated material weaknesses in its internal control over financial reporting;

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

(g) Signatures of the chief executive officer and the chief financial officer (or equivalent position/title).

(5) Management shall document and make available upon financial condition examination the basis upon which its assertions, required in subsection (4) above, 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.

(a) 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 assertion in a cost-effective manner and, as such, may include assembly of or reference to existing documentation.

(b) Management's Report on Internal Control over Financial Reporting, required by subsection (1) above, and any documentation provided in support thereof during the course of a financial condition examination, shall be kept confidential by the state insurance department.

Sources: Laws, 2009, ch. 334, § 10, eff from and after Jan. 1, 2010.

83-5-125 - Canadian and British companies [Effective January 1, 2010].

§ 83-5-125. Canadian and British companies [Effective January 1, 2010].

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(1) 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.

(2) For such insurers, the letter required in Section 83-5-106 shall state that the accountant is aware of the requirements relating to the annual audited financial report filed with the commissioner pursuant to Section 83-5-101 and shall affirm that the opinion expressed is in conformity with those requirements.

Sources: Laws, 2009, ch. 334, § 11, eff from and after Jan. 1, 2010.

83-5-201 - Purpose of sections 83-5-201 through 83-5-217.

§ 83-5-201. Purpose of sections 83-5-201 through 83-5-217.

The purpose of Sections 83-5-201 through 83-5-217 is to provide an effective and efficient system for examining the activities, operations, financial condition and affairs of all persons transacting the business of insurance in this state and all persons otherwise subject to the jurisdiction of the commissioner. Sections 83-5-201 through 83-5-217 are intended to enable the commissioner to adopt a flexible system of examinations which directs resources as may be deemed appropriate and necessary for the administration of the insurance and insurance related laws of this state.

Sources: Laws, 1992, ch. 319, § 1, eff from and after July 1, 1992.

83-5-203 - Definitions.

§ 83-5-203. Definitions.

The following terms as used in Sections 83-5-201 through 83-5-217 shall have the respective meanings hereinafter set forth:

(a) "Commissioner" means the Commissioner of Insurance.

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(b) "Company" means any person engaging in or proposing or attempting to engage in any transaction or kind of insurance or surety business, and any person or group of persons who may otherwise be subject to the administrative, regulatory or taxing authority of the commissioner.

(c) "Department" means the Department of Insurance.

(d) "Examiner" means any individual or firm having been authorized by the commissioner to conduct an examination under this act.

(e) "Insurer" means an insurer as the term is used in Section 83-5-1.

(f) "Person" means any individual, aggregation of individuals, trust, association, partnership or corporation, or any affiliate thereof.

Sources: Laws, 1992, ch. 319, § 2, eff from and after July 1, 1992.

83-5-205 - Examination of insurers; scheduling of examinations; examination of foreign or alien insurer; acceptance of examination report prepared by insurance department of another state.

§ 83-5-205. Examination of insurers; scheduling of examinations; examination of foreign or alien insurer; acceptance of examination report prepared by insurance department of another state.

(1) The commissioner or any of his examiners may conduct an examination under Sections 83-5-201 through 83-5-217 of any company as often as the commissioner, in his or her sole discretion, deems appropriate but, at a minimum, shall conduct an examination of every insurer licensed in this state not less frequently than once every three (3) years. 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.

(2) For purposes of completing an examination of any company under Sections 83-5-201 through 83-5-217, the commissioner may examine or investigate any person, or the business of any person, insofar as such examination or investigation, in the sole discretion of the commissioner, is necessary or

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material to the examination of the company.

(3) In lieu of an examination under Sections 83-5-201 through 83-5-217 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 (a) the insurance department was at the time of the examination accredited under the National Association of Insurance Commissioners' Financial Regulation Standards and Accreditation Program; or (b) the examination is performed under the supervision of an accredited insurance department or with the participation of one or more examiners who are employed by such an accredited state insurance department and who, after a review of the examination work papers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by their insurance department.

Sources: Laws, 1992, ch. 319, § 3, eff from and after July 1, 1992.

83-5-207 - Appointment of examiners; guidelines and procedures to be followed by examiner; insurers to facilitate examination; penalties for refusal to comply with request of examiner; power of examin

§ 83-5-207. Appointment of examiners; guidelines and procedures to be followed by examiner; insurers to facilitate examination; penalties for refusal to comply with request of examiner; power of examiners; authority of commissioner to hire examiners; company examined to pay cost of examination; authority of commissioner not limited.

(1) Upon determining that an examination should be conducted, the commissioner or the commissioner's designee shall issue an examination warrant appointing one 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 such other guidelines or procedures as the commissioner may deem appropriate.

(2) Every company or person from whom information is sought, its officers, directors and agents, must provide to the examiners appointed under subsection (1) timely, convenient and free access, at all reasonable hours at its offices, to all books, records, accounts, papers, documents and any or all computer or other recordings relating to the property, assets, business and affairs of the company being examined. The officers, directors, employees and

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agents of the company or person must facilitate the examination and aid in the examination, so far as it is in their power to do so. The refusal of any company, by its officers, directors, employees or agents, 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 company 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 in accordance with Section 83-1-29, 83-5-17, 83-5-67, 83-5-83 or 83-21-13.

(3) The commissioner or any of his examiners shall have the power to issue subpoenas, to administer oaths and to examine under oath any person as to any matter pertinent to the examination. 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. Failure to obey the court order shall be punishable as contempt of court.

(4) When making an examination under Sections 83-5-201 through 83-5-217, the commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants or other professionals and specialists as examiners, the cost of which shall be borne by the company which is the subject of the examination.

(5) Nothing contained in Sections 83-5-201 through 83-5-217 shall be construed to limit the commissioner's authority to terminate or suspend any examination in order to pursue other legal or regulatory action under 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.

(6) Nothing contained in Sections 83-5-201 through 83-5-217 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, in his or her sole discretion, may deem appropriate.

Sources: Laws, 1992, ch. 319, § 4; Laws, 1997, ch. 410, § 26, eff from and after July 1, 1997.

83-5-209 - Contents of examination report; filing of report; opportunity to respond to

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§ 83-5-209. Contents of examination report; filing of report; opportunity to respond to report; review of report by and order of commissioner; hearings; confidentiality of examination reports; disclosure of reports.

(1) All examination reports shall be comprised of only facts appearing upon the books, records or other documents of the company, its agents or other persons examined, or as ascertained from the testimony of its officers or agents or other persons examined concerning its affairs and such conclusions and recommendations as the examiners find reasonably warranted from the facts.

(2) No later than sixty (60) days following completion of the examination, the examiner in charge shall file with the department a verified written report of examination under oath. Upon receipt of the verified report, the department shall transmit the report to the company examined, together with a notice which shall afford the company 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.

(3) Within thirty (30) days of the end of the period allowed for the receipt of written submissions or rebuttals, the commissioner shall fully consider and review the report, together with any written submissions or rebuttals and any relevant portions of examiner work papers and enter an order:

(a) Adopting the examination report as filed, or with modification or corrections. If the examination report reveals that the company 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 such violation; or

(b) Rejecting the examination report with directions to the examiners to reopen the examination for purposes of obtaining additional data, documentation or information and refiling in accordance with subsections (1) and (2) of this section; or

(c) 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.

(4) All orders entered in accordance with subsection (3)(a) of this section shall be accompanied by findings and conclusions resulting from the commissioner's consideration and review of the examination report, relevant

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examiner work papers, and any written submissions or rebuttals. Any such order shall be considered a final administrative decision and may be appealed under the Mississippi Administrative Procedures Act and shall be served upon the company 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.

(5) Any hearing conducted under subsection (3)(c) 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 company. Within twenty (20) days of the conclusion of any such hearing, the commissioner shall enter an order in accordance with subsection (3)(a) of this section.

(a) The commissioner shall not appoint an examiner as an authorized representative to conduct the hearing. The hearing shall proceed expeditiously with discovery by the company limited to examiner work papers which tend to substantiate any assertions set forth in any written submission or rebuttal. The commissioner or his representative may issue subpoenas for the attendance of any witnesses or the production of any documents deemed relevant to the investigation whether under the control of the department, the company or other persons. The documents produced shall be included in the record, and testimony taken by the commissioner or his representative shall be under oath and preserved for the record.

Nothing contained in this section 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.

(b) The hearing shall proceed with the commissioner or his representative posing questions to the persons subpoenaed. Thereafter, the company and the department may present testimony relevant to the investigation. Cross-examination shall be conducted only by the commissioner or his representative. The company and the department shall be permitted to make closing statements and may be represented by counsel of their choice.

(6) (a) Upon the adoption of the examination report under subsection (3)(a) of this section, the commissioner shall continue to hold the content of the examination report as private and confidential information for a period of ten (10) days except to the extent provided in subsection (2) of this section. Thereafter, the commissioner may open the report for public inspection so long

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as no court of competent jurisdiction has stayed its publication.

(b) Nothing contained in Sections 83-5-201 through 83-5-217 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, to the insurance department of this or any other state or country, or to law enforcement officials of this or any other state or agency of the federal government at any time, so long as such agency or office receiving the report or matters relating thereto agrees in writing to hold it confidential and in a manner consistent with this act.

(c) If 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.

(7) 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 Sections 83-5-201 through 83-5-217 may be held by the commissioner as a record not required to be made public under the Mississippi Public Records Act.

Sources: Laws, 1992, ch. 319, § 5, eff from and after July 1, 1992.

83-5-211 - Appointment of examiners.

§ 83-5-211. Appointment of examiners.

(1) No examiner may be appointed by the commissioner if such 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 Sections 83-5-201 through 83-5-217. This section shall not be construed to automatically preclude an examiner from being:

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

(b) 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;

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

(d) A settlor or beneficiary of a "blind trust" into which any otherwise

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impermissible holdings have been placed.

(2) Notwithstanding the requirements 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 such persons may from time to time be similarly employed or retained by persons subject to examination under Sections 83-5-201 through 83-5-217.

Sources: Laws, 1992, ch. 319, § 6, eff from and after July 1, 1992.

83-5-213 - Compensation and expenses of examiner.

§ 83-5-213. Compensation and expenses of examiner.

The compensation and expense of such examiner shall not exceed that approved by the National Association of Insurance Commissioners for all examiners on such examinations unless approved by the commissioner. An itemized account of such charges shall be submitted to and approved by the commissioner.

Sources: Laws, 1992, ch. 319, § 7; Laws, 1995, ch. 306, § 1, eff from and after passage (approved March 8, 1995).

83-5-215 - Reports to be furnished to State Tax Commission; Tax Commission not precluded from performing additional audits.

§ 83-5-215. Reports to be furnished to State Tax Commission; Tax Commission not precluded from performing additional audits.

The results of audits performed hereunder by the commissioner shall be furnished to the State Tax Commission within thirty (30) days of completion. Nothing herein shall be construed to prohibit the State Tax Commission from performing such additional audits or verifications as it may deem necessary to ensure the proper payment of taxes.

Sources: Laws, 1992, ch. 319, § 8, eff from and after July 1, 1992.

83-5-217 - No cause of action against examiners; no cause of action against person

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§ 83-5-217. No cause of action against examiners; no cause of action against person providing information to examiner; statutory privilege or immunity not abridged; examiner's right to award of attorney fees in civil action.

(1) 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 Sections 83-5-201 through 83-5-217.

(2) 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 or the commissioner's authorized representative or examiner pursuant to an examination made under Sections 83-5-201 through 83-5-217 if such act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive.

(3) This section does not abrogate or modify in any way any common law or statutory privilege or immunity heretofore enjoyed by any person identified in subsection (1) of this section.

(4) A person identified in subsection (1) of this section shall be entitled to an award of attorney's fees and costs if he or she is the prevailing party in a civil cause of action for libel, slander or any other relevant tort arising out of activities in carrying out Sections 83-5-201 through 83-5-217 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 that it was initiated.

Sources: Laws, 1992, ch. 319, § 9, eff from and after July 1, 1992.

83-5-251 - Procurer of insurance must have insurable interest; insurable interest defined; insurer reliance on applicant's representations; insurable interest of charitable, etc. organization.

§ 83-5-251. Procurer of insurance must have insurable interest; insurable interest defined; insurer reliance on applicant's representations; insurable interest of charitable, etc. organization.

(1) Any individual of competent legal capacity may procure or effect an

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insurance contract upon his own life or body for the benefit of any person, but no person shall procure or cause to be procured any insurance contract upon the life or body of another individual unless the benefits under such contract are payable to the insured or his personal representatives or to a person having, at the time when such contract was made, an insurable interest in the insured.

(2) If the beneficiary, assignee or other payee under any contract made in violation of this section receives from the insurer any benefits from such contract accruing upon the death, disablement or injury of the insured, the insured or his executor or administrator may maintain an action to recover such benefits from the person so receiving them.

(3) For purposes of Sections 83-5-251 through 83-5-257; "insurable interest" means that a person has an insurable interest in the life, body and health of another individual as follows:

(a) The individual and the insured are related closely by blood or by law, a substantial interest engendered by love and affection;

(b) The person has a lawful and substantial economic interest in having the life, health or bodily safety of the insured continue, as distinguished from an interest which would arise only by, or would be enhanced in value by, the death, disablement or injury of the insured;

(c) A party to a contract or option for the purchase or sale of an interest in a business proprietorship, partnership or firm, or of shares of stock of a closed corporation or of an interest in such shares, has an insurable interest in the life, body and health of each individual party to such contract and for the purposes of such contract only, in addition to any insurable interest which may exist as to such individual;

(d) A person has a lawful interest in having the funeral expenses of the insured paid through insurance, provided the insured has knowledge of such insurance; and

(e) Any religious, educational, eleemosynary, charitable or benevolent institution or its agency may be named beneficiary in any policy of life insurance issued by any insurance company upon the life of any individual. A religious, educational, eleemosynary, charitable or benevolent institution or its agency designated as a beneficiary has an insurable interest for the full face of the policy and is entitled to collect the full face of the policy. Such institutions named as beneficiaries in policies issued before July 1, 1992, shall have an insurable interest for the full face of the policy and are entitled to collect the full face of the policy.

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(4) An insurer shall be entitled to rely upon all reasonable statements, declarations and representations made by an applicant for insurance relative to the existence of an insurable interest; and no insurer shall incur legal liability except as set forth in the policy, by virtue of any untrue statements, declarations or representations so relied upon in good faith by the insurer.

(5) "Person" as used herein means artificial as well as natural persons, includes all public and private corporations as well as individuals, and includes a trust whose principal beneficiaries have an "insurable interest" as used herein. Any trust with policies issued after July 1, 1992, shall be deemed persons under this section.

Sources: Laws, 1992, ch. 522, § 1; Laws, 1993, ch. 400, § 1, eff from and after passage (approved March 15, 1993).

§ 83-5-253. Consent of insured required in certain cases.

No life or health insurance contract upon an individual, except a contract of group life insurance or annuity or of group health insurance, or replacement contracts, shall be made or effectuated, unless at the time of the making of the contract the insured, applies therefor or has consented thereto in writing or has had the application acknowledged in writing by the insurance company, except that 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 effectuate insurance upon the life of or pertaining to such minor.

Sources: Laws, 1992, ch. 522, § 2, eff from and after July 1, 1992.

§ 83-5-255. Enforcement by Commissioner.

The Commissioner of Insurance is authorized to use any of the powers established under the insurance laws of the state to enforce Sections 83-5-251 through 83-5-257.

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Sources: Laws, 1992, ch. 522, § 3, eff from and after July 1, 1992.

83-5-257 - Provisions cumulative of existing statutory and common law.

§ 83-5-257. Provisions cumulative of existing statutory and common law.

Sections 83-5-251 through 83-5-257 are cumulative of existing law in Mississippi, statutory and common law on the question of insurable interest.

Sources: Laws, 1992, ch. 522, § 4, eff from and after July 1, 1992.

83-5-301 - Applicability of article.

§ 83-5-301. Applicability of article.

This article shall apply to all domestic, foreign and alien insurers authorized to transact business in this state.

Sources: Laws, 1994, ch. 646, § 1, eff from and after passage (approved April 8, 1994).

83-5-303 - Annual filings; hardship exemption; foreign insurers.

§ 83-5-303. Annual filings; hardship exemption; foreign insurers.

(1) (a) Each domestic, foreign and alien insurer authorized to transact insurance in this state shall annually on or before March 1 of each year, file with the National Association of Insurance Commissioners a copy of its annual statement convention blank, along with such additional filings as prescribed by the Commissioner of Insurance 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 of Insurance 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 of Insurance shall also be filed with the National Association of Insurance Commissioners.

(b) The Commissioner of Insurance may grant a hardship exemption to any domestic industrial life company transacting business in Mississippi only. No

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exemption shall be granted to any industrial life company transacting business across state lines.

(2) Foreign insurers that are domiciled in a state which has a law substantially similar to subsection (1) of this section shall be deemed in compliance with this section.

Sources: Laws, 1994, ch. 646, § 2, eff from and after passage (approved April 8, 1994).

83-5-305 - Civil liability of those dealing with information developed from filings.

§ 83-5-305. Civil liability of those dealing with information developed from filings.

In the absence of actual malice, 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 from the filing of the annual statement convention blanks shall be acting as agents of the Commissioner of Insurance under the authority of this article and, while performing such tasks, shall be subject to civil liability only to the same extent as the Commissioner of Insurance.

Sources: Laws, 1994, ch. 646, § 3, eff from and after passage (approved April 8, 1994).

83-5-307 - Confidentiality.

§ 83-5-307. Confidentiality.

All financial analysis ratios and examination synopses concerning insurance companies that are submitted to the Department of Insurance by the National Association of Insurance Commissioners' Insurance Regulatory Information System are confidential and may not be disclosed by the department.

Sources: Laws, 1994, ch. 646, § 4, eff from and after passage (approved April

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8, 1994).

83-5-309 - Failure to file; revocation, suspension or refusal of certificate of authority.

§ 83-5-309. Failure to file; revocation, suspension or refusal of certificate of authority.

The Commissioner of Insurance may suspend, revoke or refuse to renew the certificate of authority of any insurer failing to file its annual statement when due or within any extension of time which the commissioner, for good cause, may have granted.

Sources: Laws, 1994, ch. 646, § 5, eff from and after passage (approved April 8, 1994).

83-5-351 - Filing report; disclosure of material acquisitions and dispositions.

§ 83-5-351. Filing report; disclosure of material acquisitions and dispositions.

(1) Every insurer domiciled in this state shall file a report with the Commissioner of Insurance 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 under other provisions of the insurance laws, regulations or other requirements.

(2) The report required in subsection (1) of this section is due within fifteen (15) days after the end of the calendar month in which any of the transactions described in subsection (1) of this section occur.

(3) One (1) complete copy of the report, including any exhibits or other attachments, shall also be filed with the National Association of Insurance Commissioners.

(4) All reports obtained by or disclosed to the commissioner under this article shall be confidential treatment and shall not be subject to subpoena and shall not be made public by the commissioner, the National Association of

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Insurance Commissioners or any other person, except to insurance departments of other states, without the prior written consent of the insurer to which it pertains unless the commissioner, after giving the insurer who would be affected notice and an opportunity to be heard, determines that the interest of policy holders, shareholders or the public will be served by publication, in which event the commissioner may publish all or any part in the manner the commissioner determines appropriate.

Sources: Laws, 1996, ch. 354, § 1, eff from and after July 1, 1996.

83-5-353 - Purpose.

§ 83-5-353. Purpose.

(1) No acquisitions or dispositions of assets need be reported under Section 83-5-351 if the acquisitions or dispositions are not material. For purposes of this article, a material acquisition or the aggregate of any series of related acquisitions during any thirty-day period or disposition or the aggregate of any series of related dispositions during any thirty-day period is one that is nonrecurring and not in the ordinary course of business and involves more than five percent (5%) of the reporting insurer's total admitted assets as reported in its most recent financial statement filed with the commissioner.

(2) (a) 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) Asset dispositions subject to this article include every sale, lease, exchange, merger, consolidation, mortgage, hypothecation, assignment whether for the benefit of creditors or otherwise, abandonment, destruction or other disposition.

(3) (a) 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;

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

(4) 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 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 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.

Sources: Laws, 1996, ch. 354, § 2, eff from and after July 1, 1996.

83-5-355 - No reporting of nonrenewals; cancellations; or revisions of ceded reinsurance agreements.

§ 83-5-355. No reporting of nonrenewals; cancellations; or revisions of ceded reinsurance agreements.

(1) No nonrenewals, cancellations or revisions of ceded reinsurance agreements need be reported under Section 83-5-351 if the nonrenewals, cancellations or revisions are not material. For purposes of this article, a material nonrenewal, cancellation or revision is one that affects:

(a) As respects property and casualty business, including accident and health business written by a property and casualty insurer:

(i) More than fifty percent (50%) of the insurer's total ceded written premium; or

(ii) More than fifty percent (50%) of the insurer's total ceded indemnity and loss adjustment reserves.

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(b) As respects 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 recent annual statement.

(c) As respects either property and casualty or life, annuity, and accident and health business, either of the following events shall constitute a material revision which must be reported:

(i) An authorized reinsurer representing more than ten percent (10%) of a total cession is replaced by one or more unauthorized reinsurers; or

(ii) Previously established collateral requirements have been reduced or waived as respects one or more unauthorized reinsurers representing collectively more than ten percent (10%) of a total cession.

(2) However, no filing shall be required if:

(a) As respects property and casualty business, including accident and health business written by a property and casualty insurer: the insurer's total ceded written premium represents, on an annualized basis, less than ten percent (10%) of its total written premium for direct and assumed business, or

(b) As respects life, annuity, and accident and health business: the total reserve credit taken from business ceded represents, on an annualized basis, less than ten percent (10%) of the statutory reserve requirement before any cession.

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

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

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

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

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

(4) 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

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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 that 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.

Sources: Laws, 1996, ch. 354, § 3, eff from and after July 1, 1996.

83-5-357 - Promulgation of rules and regulations.

§ 83-5-357. Promulgation of rules and regulations.

The commissioner, after notices and hearings, may promulgate rules and regulations necessary to carry out the provisions of this article.

Sources: Laws, 1996, ch. 354, § 4, eff from and after July 1, 1996.

83-5-401 - Definitions.

§ 83-5-401. Definitions.

As used in Sections 83-5-401 through 83-5-427, the following words and phrases shall have the meanings ascribed herein unless the context clearly indicates otherwise:

(a) "Adjusted RBC report" means a risk-based capital report which has been adjusted by the commissioner in accordance with Section 83-5-403(4).

(b) "Corrective order" means an order issued by the commissioner specifying corrective actions which the commissioner has determined are required.

(c) "Domestic insurer" means any insurance company domiciled in this state.

(d) "Foreign insurer" means any insurance company which is licensed to do business in this state under Section 83-21-1 et seq., but is not domiciled in this state.

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(e) "NAIC" means the National Association of Insurance Commissioners.

(f) "Life and/or health insurer" means any insurance company licensed under Section 83-19-1 et seq., or a licensed property and casualty insurer writing only accident and health insurance.

(g) "Property and casualty insurer" means any insurance company licensed under Section 83-19-1 et seq., but shall not include monoline mortgage guaranty insurers, financial guaranty insurers and title insurers.

(h) "Negative trend" means, with respect to a life and/or health insurer, negative trend over a period of time, as determined in accordance with the "Trend Test Calculation" included in the RBC instructions.

(i) "RBC instructions" means the RBC report including risk-based capital instructions adopted by the NAIC, as such RBC instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

(j) "RBC level" means an insurer's company action level RBC, regulatory action level RBC, authorized control level RBC, or mandatory control level RBC where:

(i) "Company action level RBC" means, with respect to any insurer, the product of 2.0 and its authorized control level RBC;

(ii) "Regulatory action level RBC" means the product of 1.5 and its authorized control level RBC;

(iii) "Authorized control level RBC" means the number determined under the risk-based capital formula in accordance with the RBC instructions;

(iv) "Mandatory control level RBC" means the product of .70 and the authorized control level RBC.

(k) "RBC plan" means a comprehensive financial plan containing the elements specified in Section 83-5-405(2). 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."

(l) "RBC report" means the report required in Section 83-5-403.

(m) "Total adjusted capital" means the sum of:

(i) An insurer's statutory capital and surplus as determined in accordance

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with the statutory accounting applicable to the annual financial statements required to be filed under Section 83-5-55; and

(ii) Such other items, if any, as the RBC instructions may provide.

Sources: Laws, 1996, ch. 478, § 1, eff from and after July 1, 1996.

83-5-403 - Filing of RBC report; determination of insurer's RBC; maintenance of capital above prescribed RBC level; adjustment of report.

§ 83-5-403. Filing of RBC report; determination of insurer's RBC; maintenance of capital above prescribed RBC level; adjustment of report.

(1) Every domestic insurer shall, on or before each March 1, the filing date, 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 such information as is required by the RBC instructions. In addition, every domestic insurer shall file its RBC report:

(a) With the NAIC in accordance with the RBC instructions; and

(b) 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:

(i) Fifteen (15) days from the receipt of notice to file its RBC report with that state; or

(ii) The filing date.

(2) A life and health insurer's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take into account, and may adjust for the covariance between, the following factors determined in each case by applying the factors in the manner set forth in the RBC instructions.

(a) The risk with respect to the insurer's assets;

(b) The risk of adverse insurance experience with respect to the insurer's liabilities and obligations;

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(c) The interest rate risk with respect to the insurer's business; and

(d) All other business risks and such other relevant risks as are set forth in the RBC instructions.

(3) A property and casualty insurer's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take the following into account, and may adjust for the covariance between, determined in each case by applying the factors in the manner set forth in the RBC instructions:

(a) Asset risk;

(b) Credit risk;

(c) Underwriting risk; and

(d) All other business risks and such other relevant risks as are set forth in the RBC instructions.

(4) Insurers may maintain capital above the RBC levels required by Sections 83-5-401 through 83-5-427.

(5) If a domestic insurer files a RBC report which in the judgment of the commissioner is inaccurate, then 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."

Sources: Laws, 1996, ch. 478, § 2, eff from and after July 1, 1996.

83-5-405 - Procedure upon occurrence of company action level event.

§ 83-5-405. Procedure upon occurrence of company action level event.

(1) "Company action level event" means any of the following events:

(a) The filing of a RBC report by an insurer which indicates that:

(i) 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; or

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(ii) If a life and/or health 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 its authorized control level RBC and 2.5 and has a negative trend;

(b) The notification by the commissioner to the insurer of an adjusted RBC report that indicates an event in paragraph (a) of this subsection, provided the insurer does not challenge the adjusted RBC report under Section 83-5-413; or

(c) If, under Section 83-5-413, an insurer challenges an adjusted RBC report that indicates the event in paragraph (a) of this subsection, the notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(2) In the event of a company action level event, the insurer shall prepare and submit to the commissioner a RBC plan which shall:

(a) Identify the conditions which contribute to the company action level event;

(b) 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;

(c) 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. The projections for both new and renewal business might include separate projections for each major line of business and separately identify each significant income, expense and benefit component;

(d) Identify the key assumptions impacting the insurer's projections and the sensitivity of the projections to the assumptions; and

(e) 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, if any, in each case.

(3) The RBC plan shall be submitted:

(a) Within forty-five (45) days of the company action level event; or

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(b) If the insurer challenges an adjusted RBC report under Section 83-5-413, within forty-five (45) days after notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(4) Within sixty (60) days after the submission by an insurer of a 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:

(a) Within forty-five (45) days after the notification from the commissioner; or

(b) If the insurer challenges the notification from the commissioner under Section 83-5-413, within forty-five (45) days after a notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(5) 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 the commission's discretion, subject to the insurer's right to a hearing under Section 83-5-413, specify in the notification that the notification constitutes a regulatory action level event.

(6) Every domestic insurer that files a 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:

(a) Such state has a RBC provision substantially similar to Section 83-5-415(1); and

(b) 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:

(i) Fifteen (15) days after the receipt of notice to file a copy of its RBC plan or revised RBC plan with the state; or

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(ii) The date on which the RBC plan or revised RBC plan is filed under Section 83-5-405(3) and (4).

Sources: Laws, 1996, ch. 478, § 3, eff from and after July 1, 1996.

83-5-407 - Procedure upon occurrence of regulatory action level event.

§ 83-5-407. Procedure upon occurrence of regulatory action level event.

(1) "Regulatory action level event" means, with respect to any insurer, any of the following events:

(a) The filing of a 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;

(b) The notification by the commissioner to an insurer of an adjusted RBC report that indicates the event in paragraph (a) of this subsection, provided the insurer does not challenge the adjusted RBC report under Section 83-5-413;

(c) If under Section 83-5-413, the insurer challenges an adjusted RBC report that indicates the event in paragraph (a) of this subsection, the notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge;

(d) The failure of the insurer to file a RBC report by the filing date, unless the insurer has provided an explanation for such failure which is satisfactory to the commissioner and has cured the failure within ten (10) days after the filing date;

(e) The failure of the insurer to submit a RBC plan to the commissioner within the time period set forth in Section 83-5-405(3);

(f) Notification by the commissioner to the insurer that;

(i) The RBC plan or revised RBC plan submitted by the insurer is, in the judgment of the commissioner, unsatisfactory; and

(ii) Such notification constitutes a regulatory action level event with respect to the insurer, provided the insurer has not challenged the determination under Section 83-5-413;

(g) If, under Section 83-5-413, the insurer challenges a determination by the

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commissioner under paragraph (f) of this subsection, the notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected such challenge;

(h) 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 such 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 Section 83-5-413; or

(i) If, under Section 83-5-413, the insurer challenges a determination by the commissioner under paragraph (h) of this subsection, the notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the challenge.

(2) In the event of a regulatory action level event the commissioner shall:

(a) Require the insurer to prepare and submit an RBC plan or, if applicable, a revised RBC plan;

(b) Perform such examination or analysis as the commissioner deems necessary of the assets, liabilities and operations of the insurer including a review of its RBC plan or revised RBC plan; and

(c) Subsequent to the examination or analysis, issue an order specifying such corrective actions as the commissioner shall determine are required.

(3) In determining corrective actions, the commissioner may take into account such factors as are deemed relevant with respect to the insurer based upon the commissioner's examination or analysis of the assets, liabilities and operations of the insurer, including, but not limited to, the results of any sensitivity tests undertaken in accordance with the RBC instructions. The RBC plan or revised RBC plan shall be submitted:

(a) Within forty-five (45) days after the occurrence of the regulatory action level event;

(b) If the insurer challenges an adjusted RBC report under Section 83-5-413 and the challenge is not frivolous in the judgment of the commissioner, within forty-five (45) days after the notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge; or

(c) If the insurer challenges a revised RBC plan under Section 83-5-413 and the challenge is not frivolous in the judgment of the commissioner, within

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forty-five (45) days after the notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(4) The commissioner may retain actuaries and investment experts and other consultants as may be 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 such other party as directed by the commissioner.

Sources: Laws, 1996, ch. 478, § 4, eff from and after July 1, 1996.

83-5-409 - Procedure upon occurrence of authorized control level event.

§ 83-5-409. Procedure upon occurrence of authorized control level event.

(1) "Authorized control level event" means any of the following events:

(a) The filing of a 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;

(b) The notification by the commissioner to the insurer of an adjusted RBC report that indicates the event in paragraph (a) of this subsection, if the insurer does not challenge the adjusted RBC report under Section 83-5-413;

(c) Under Section 83-5-413, the insurer challenges an adjusted RBC report that indicates the event in paragraph (a) of this subsection, notification by the commissioner to the insurer that the commissioner, after a hearing, has rejected the insurer's challenge;

(d) The failure of the insurer to respond, in a manner satisfactory to the commissioner, to a corrective order if the insurer has not challenged the corrective order under Section 83-5-413; or

(e) If the insurer has challenged a corrective order under Section 83-5-413 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 rejection or modification by the commissioner.

(2) In the event of an authorized control level event with respect to an

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insurer, the commissioner shall:

(a) Take such actions as are required under Section 83-5-407 regarding an insurer with respect to which a regulatory action level event has occurred; or

(b) If the commissioner determines it to be in the best interests of the policyholders and creditors of the insurer and of the public, take such actions as are necessary to cause the insurer to be placed under regulatory control under Section 83-24-1 et seq. 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 Section 83-24-1 et seq., and the commissioner shall have the rights, powers and duties with respect to the insurer as are set forth in Section 83-24-1 et seq. In the event the commissioner takes actions under this paragraph under an adjusted RBC report, the insurer shall be entitled to such protections as are afforded to insurers under the provisions of Section 83-24-1 et seq., pertaining to summary proceedings.

Sources: Laws, 1996, ch. 478, § 5, eff from and after July 1, 1996.

83-5-411 - Procedure upon occurrence of mandatory control level event.

§ 83-5-411. Procedure upon occurrence of mandatory control level event.

(1) "Mandatory control level event" means any of the following events:

(a) The filing of a RBC report which indicates that the insurer's total adjusted capital is less than its mandatory control level RBC.

(b) Notification by the commissioner to the insurer of an adjusted RBC report that indicates the event in paragraph (a) of this subsection, if the insurer does not challenge the adjusted RBC report under Section 83-5-413; or

(c) If, under Section 83-5-413, the insurer challenges an adjusted RBC report that indicates the event in paragraph (a) of this subsection, notification by the commissioner to the insurer that the commissioner, after a hearing, has rejected the insurer's challenge.

(2) In the event of a mandatory control level event:

(a) With respect to a life insurer, the commissioner shall take such actions as are necessary to place the insurer under regulatory control under Section 83-24-1 et seq. In that event, the mandatory control level event shall be

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deemed sufficient grounds for the commissioner to take action under Section 83-24-1 et seq., and the commissioner shall have the rights, powers and duties with respect to the insurer as are set forth in Section 83-24-1 et seq. If the commissioner takes actions under an adjusted RBC report, the insurer shall be entitled to the protections of law 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-day period.

(b) With respect to a property and casualty insurer, the commissioner shall take such actions as are necessary to place the insurer under regulatory control under Section 83-24-1 et seq., 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 Section 83-24-1 et seq., and the commissioner shall have the rights, powers and duties with respect to the insurer as are set forth in Section 83-24-1 et seq. If the commissioner takes actions under an adjusted RBC report, the insurer shall be entitled to the protections of law 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-day period.

Sources: Laws, 1996, ch. 478, § 6, eff from and after July 1, 1996.

83-5-413 - Hearings.

§ 83-5-413. Hearings.

In order to maintain the integrity of proceedings and prevent undue advantage to a competitor by disclosure of proprietary information, the insurer shall have the right to a confidential departmental hearing, on a record, at which the insurer may challenge any determination or action by the commissioner after notification by the commissioner as provided in this section. The insurer shall notify the commissioner of its request for a hearing within five (5) days after the notification by the commissioner under paragraph (a), (b), (c) or (d) of this section. Upon receipt of the insurer's request for a hearing, the commissioner shall set a date for the hearing, which date shall be no less than ten (10) nor more than thirty (30) days after the date of the insurer's request.

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The notifications are as follows:

(a) Notification to an insurer by the commissioner of an adjusted RBC report; or

(b) Notification to an insurer by the commissioner that:

(i) The insurer's RBC plan or revised RBC plan is unsatisfactory; and

(ii) Such notification constitutes a regulatory action level event with respect to such insurer; or

(c) Notification to any insurer by the commissioner that the insurer has failed to adhere to its RBC plan or revised RBC plan and that such 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

(d) Notification to an insurer by the commissioner of a corrective order with respect to the insurer.

Sources: Laws, 1996, ch. 478, § 7, eff from and after July 1, 1996.

83-5-415 - Confidentiality of reports and plans; publication, dissemination, etc., of information regarding capital level of insurer; rebuttal by insurer of materially false statement regarding capita

§ 83-5-415. Confidentiality of reports and plans; publication, dissemination, etc., of information regarding capital level of insurer; rebuttal by insurer of materially false statement regarding capital level; use by commissioner of RBC instructions, reports and plans.

(1) All RBC reports, to the extent the information therein 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 an insurer performed pursuant hereto and any corrective order issued by the commissioner, as a result of 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

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competitors and shall be kept confidential by the commissioner. This information shall not be made public or be subject to subpoena, other than by the commissioner and then only for the purpose of enforcement actions taken by the commissioner under Sections 83-5-401 through 83-5-427 or any other provision of the insurance laws of this state. All RBC reports and RBC plans filed with the commissioner shall be privileged and exempt from the provisions of the Mississippi Public Records Act in accordance with Section 25-61-11.

(2) The comparison of an insurer'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 insurer and is not intended as a means to rank insurers generally. Except as otherwise required under the provisions of Sections 83-5-401 through 83-5-427, 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 in any other way, an advertisement, announcement or statement containing an assertion, 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 the falsity of such statement, or the inappropriateness, as the case may be, then the insurer may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

(3) RBC instructions, RBC reports, adjusted RBC reports, RBC plans and revised RBC plans are intended solely for use by the commissioner in monitoring the solvency of insurers and the need for possible corrective action with respect to insurers and 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 which an insurer or any affiliate is authorized to write.

Sources: Laws, 1996, ch. 478, § 8, eff from and after July 1, 1996.

83-5-417 - Relationship with other laws; promulgation of rules and regulations; exemption of domestic insurers.

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§ 83-5-417. Relationship with other laws; promulgation of rules and regulations; exemption of domestic insurers.

(1) The provisions of Sections 83-5-401 through 83-5-427 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.

(2) The commissioner may promulgate rules and regulations necessary for the implementation of Sections 83-5-401 through 83-5-427.

(3) The commissioner may exempt from the application of Sections 83-5-401 through 83-5-427 any domestic insurer that:

(a) Writes direct business only in this state;

(b) Writes direct annual premiums of Two Million Dollars ($2,000,000.00) or less; and

(c) Assumes no reinsurance in excess of five percent (5%) of direct premium written.

Sources: Laws, 1996, ch. 478, § 9, eff from and after July 1, 1996.

83-5-419 - Filing of RBC report or plan by foreign insurer.

§ 83-5-419. Filing of RBC report or plan by foreign insurer.

(1) Any foreign insurer, upon the written request of the commissioner, shall submit to the commissioner a RBC report as of the end of the calendar year just ended the later of:

(a) The date a RBC report would be required to be filed by a domestic insurer under Sections 83-5-401 through 83-5-427; or

(b) Fifteen (15) days after the request is received by the foreign insurer.

Any foreign insurer 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.

(2) In the event of a company action level event, regulatory action level

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event or authorized control level event with respect to any foreign insurer as determined under the RBC statute applicable in the state of domicile of the insurer, or, if no RBC statute is in force in that state, under the provisions of Sections 83-5-401 through 83-5-427, if the insurance commissioner of the state of domicile of the foreign insurer fails to require the foreign insurer to file a RBC plan in the manner specified under that state's RBC statute, or if no RBC statute is in force in that state, under Section 83-5-405, the commissioner may require the foreign insurer to file a RBC plan with the commissioner. In such event, the failure of the foreign insurer to file a RBC plan with the commissioner shall be grounds to order the insurer to cease writing new insurance business in this state.

(3) 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 to the court as permitted under Section 83-24-1 et seq., with respect to the liquidation of property of foreign insurers found in this state, and the occurrence of the mandatory control level event shall be considered adequate grounds for the application.

Sources: Laws, 1996, ch. 478, § 10, eff from and after July 1, 1996.

83-5-421 - Liability of commissioner, department, employees or agents.

§ 83-5-421. Liability of commissioner, department, employees or agents.

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 Sections 83-5-401 through 83-5-427.

Sources: Laws, 1996, ch. 478, § 11, eff from and after July 1, 1996.

83-5-423 - Severability of provisions.

§ 83-5-423. Severability of provisions.

If any provision of Sections 83-5-401 through 83-5-427, or the application

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thereof to any person or circumstance, is held invalid, such determination shall not affect the provisions or applications of Sections 83-5-401 through 83-5-427 which can be given effect without the invalid provision or application, and to that end the provisions of Sections 83-5-401 through 83-5-427 are severable.

Sources: Laws, 1996, ch. 478, § 12, eff from and after July 1, 1996.

83-5-425 - Effective date of notices.

§ 83-5-425. Effective date of notices.

All notices by the commissioner to an insurer which may result in regulatory action hereunder shall be effective upon dispatch if transmitted by registered or certified mail, or in the case of any other transmissions shall be effective upon the insurer's receipt of such notice.

Sources: Laws, 1996, ch. 478, § 13, eff from and after July 1, 1996.

83-5-427 - Requirements for RBC reports for 1996.

§ 83-5-427. Requirements for RBC reports for 1996.

(1) For RBC reports required to be filed by life insurers with respect to 1996, the following requirements shall apply in lieu of the provisions of Sections 83-5-405, 83-5-407, 83-5-409, and 83-5-411.

(a) In the event of a company action level event with respect to a domestic insurer, the commissioner shall take no regulatory action hereunder.

(b) In the event of a regulatory action level event under Section 83-5-407(1)(a), (b) or (c), the commissioner shall take the actions required under Section 83-5-405.

(c) In the event of a regulatory action level event under Section 83-5-407(1)(d), (e), (f), (g), (h) or (i), or an authorized control level event, the commissioner shall take the actions required under § 83-5-407 with respect to the insurer.

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(d) In the event of a mandatory control level event with respect to an insurer, the commissioner shall take the actions required under Section 83-5-409 with respect to the insurer.

(2) For RBC reports required to be filed by property and casualty insurers with respect to 1996, the following requirements shall apply in lieu of the provisions of Sections 83-5-405, 83-5-407, 83-5-409, and 83-5-411:

(a) In the event of a company action level event with respect to a domestic insurer, the commissioner shall take no regulatory action hereunder.

(b) In the event of a regulatory action level event under Section 83-5-407(1)(a), (b) or (c), the commissioner shall take the actions required under Section 83-5-405.

(c) In the event of a regulatory action level event under Section 83-5-407(1)(d), (e), (f), (g), (h) or (i), or an authorized control level event, the commissioner shall take the actions required under § 83-5-407 with respect to the insurer.

(d) In the event of a mandatory control level event with respect to an insurer, the commissioner shall take the actions required under Section 83-5-409 with respect to the insurer.

Sources: Laws, 1996, ch. 478, § 14, eff from and after July 1, 1996.

83-5-501 - Title [Effective January 1, 2010; repealed effective June 30, 2012].

§ 83-5-501. Title [Effective January 1, 2010; repealed effective June 30, 2012].

Sections 83-5-501 through 83-5-505 shall be known as the "Property and Casualty Actuarial Opinion Act."

Sources: Laws, 2009, ch. 441, § 1, eff from and after Jan. 1, 2010.

83-5-503 - Actuarial opinion of reserves and supporting documentation [Effective January 1, 2010; repealed effective June 30, 2012].

§ 83-5-503. Actuarial opinion of reserves and supporting documentation [Effective January 1, 2010; repealed effective June 30, 2012].

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(1) Statement of Actuarial Opinion. 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 (NAIC) Property and Casualty Annual Statement Instructions.

(2) Actuarial Opinion Summary.

(a) 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 NAIC Property and Casualty Annual Statement Instructions and shall be considered as a document supporting the actuarial opinion required in subsection (1).

(b) A company licensed but not domiciled in this state shall provide the actuarial opinion summary upon request.

(3) Actuarial Report and Workpapers.

(a) An actuarial report and underlying workpapers as required by the appropriate NAIC Property and Casualty Annual Statement Instructions shall be prepared to support each actuarial opinion.

(b) If the insurance company fails to provide a supporting actuarial report and/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.

(4) 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.

Sources: Laws, 2009, ch. 441, § 2, eff from and after Jan. 1, 2010.

83-5-505 - Confidentiality [Effective January 1, 2010; repealed effective June 30, 2012].

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§ 83-5-505. Confidentiality [Effective January 1, 2010; repealed effective June 30, 2012].

(1) The statement of actuarial opinion shall be provided with the annual statement in accordance with the appropriate NAIC Property and Casualty Annual Statement Instructions and shall be treated as a public document.

(2) (a) Documents, materials or other information in the possession or control of the Department of Insurance 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 the Mississippi 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.

(b) This section shall not be construed to limit the commissioner's authority to release the documents to the Actuarial Board for Counseling and Discipline (ABCD) so long as the material is required for the purpose of professional disciplinary proceedings and that the ABCD 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.

(3) 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 (2).

(4) In order to assist in the performance of the commissioner's duties, the commissioner:

(a) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to subsection (2) 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;

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(b) May 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

(c) May enter into agreements governing sharing and use of information consistent with subsections (2), (3) and (4).

(5) 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 (4).

Sources: Laws, 2009, ch. 441, § 3, eff from and after Jan. 1, 2010.

83-5-507 - Repeal of §§ 83-5-501 through 83-5-507 [Effective January 1, 2010; repealed effective June 30, 2012].

§ 83-5-507. Repeal of §§ 83-5-501 through 83-5-507 [Effective January 1, 2010; repealed effective June 30, 2012].

Sections 83-5-501 through 83-5-507 shall stand repealed from and after June 30, 2012.

Sources: Laws, 2009, ch. 441, § 4, eff from and after Jan. 1, 2010.

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