INSURANCE CODE - INS

DIVISION 1. GENERAL RULES GOVERNING INSURANCE [100. - 1879.8.] *(Division 1 enacted by Stats. 1935, Ch. 145.)*

PART 2. THE BUSINESS OF INSURANCE [680. - 1879.8.] *(Part 2 enacted by Stats. 1935, Ch. 145.)*

CHAPTER 1. General Regulations [680. - 1113.] *(Chapter 1 enacted by Stats. 1935, Ch. 145.)*

ARTICLE 6. Misrepresentation of Policies [780. - 784.] *(Article 6 enacted by Stats. 1935, Ch. 145.)*

780. An insurer or officer or agent thereof, or an insurance broker or solicitor shall not cause or permit to be issued, circulated or used, any statement that is known, or should have been known, to be a misrepresentation of the following:

(a) The terms of a policy issued by the insurer or sought to be negotiated by the person making or permitting the misrepresentation.

(b) The benefits or privileges promised thereunder.

(c) The future dividends payable thereunder.

(Amended by Stats. 2004, Ch. 730, Sec. 1. Effective January 1, 2005.)

781. (a) A person shall not make any statement that is known, or should have been known, to be a misrepresentation (1) to any other person for the purpose of inducing, or tending to induce, such other person either to take out a policy of insurance, or to refuse to accept a policy issued upon an application therefor and instead take out any policy in another insurer, or (2) to a policyholder in any insurer for the purpose of inducing or tending to induce him or her to lapse, forfeit or surrender his or her insurance therein.

(b) A person shall not make any representation or comparison of insurers or policies to an insured which is misleading, for the purpose of inducing or tending to induce him or her to lapse, forfeit, change or surrender his or her insurance, whether on a temporary or permanent plan.

(Amended by Stats. 2004, Ch. 730, Sec. 2. Effective January 1, 2005.)

782. Any person who violates the provisions of Section 780 or 781 is punishable by a fine not exceeding twenty-five thousand dollars ($25,000), or in a case in which the loss of the victim exceeds ten thousand dollars ($10,000), by a fine not exceeding three times the amount of the loss suffered by the victim, by imprisonment in a county jail for a period not to exceed one year, or by both a fine and imprisonment. Restitution to the victim ordered pursuant to Section 1202.4 of the Penal Code shall be satisfied before any fine imposed by this section is collected.

(Amended by Stats. 2004, Ch. 730, Sec. 3. Effective January 1, 2005.)

783. Whenever any insurance agent, broker, or solicitor knowingly violates any provisions of Sections 780 or 781, the commissioner, after a hearing in accordance with the procedure provided in Article 13 of Chapter 5 of this part, may suspend the license of any such person for not exceeding three years.

(Amended by Stats. 1959, Ch. 4.)

783.5. If an insurer knowingly violates any provision of Sections 780 or 781, or knowingly permits any officer, agent, or employee so to do, the commissioner, after a hearing in accordance with the procedure provided in Section 704, may suspend the insurer's certificate of authority to do the class of insurance in respect to which the violation occurred.

(Amended by Stats. 1945, Ch. 901.)

784. Any person may be compelled to testify and produce books and writings at the trial or hearing of any person charged with violating any provision of sections 780 or 781 even though such testimony or evidence may incriminate him. A person shall not be prosecuted for any act concerning which he is compelled so to testify or produce evidence, except for perjury committed in so testifying.

(Enacted by Stats. 1935, Ch. 145.)

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CHAPTER 1. General Regulations [680. - 1113.] *(Chapter 1 enacted by Stats. 1935, Ch. 145.)*

ARTICLE 6.3. Senior Insurance [785. - 789.10.] *(Article 6.3 added by Stats. 1990, Ch. 1454, Sec. 1.)*

785. (a) All insurers, brokers, agents, and others engaged in the transaction of insurance owe a prospective insured who is 65 years of age or older, a duty of honesty, good faith, and fair dealing. This duty is in addition to any other duty, whether express or implied, that may exist.

(b) Conduct of an insurer, broker, or agent, or other person engaged in the transaction of insurance, during the offer and sale of a policy or certificate previous to the purchase is relevant to any action alleging a breach of the duty of good faith and fair dealing.

(c) Except where explicitly provided to the contrary, this article shall not apply to any of the following:

(1) Medicare supplement insurance as defined in subdivision (m) of Section 10192.4.

(2) Long-term care insurance as defined in Section 10231.2.

(3) Disability coverage provided through the insured's employer or former employer.

(4) Disability insurance policies or certificates principally designed to provide coverage for accidents or expenses incurred while traveling if the premium for the policy or certificate is ten dollars ($10) or less.

(5) Blanket disability insurance as defined in Section 10270.3.

(6) Credit disability insurance as defined in Section 779.2.

(7) Accidental death insurance.

(8) Until January 1, 2002, disability policies or certificates that are sold through direct response methods of delivery.

(9) Disability income insurance as defined in subdivision (i) of Section 799.01.

(d) Provided that the requirements of Section 10296 are met, this article shall not apply to transportation ticket policies and baggage insurance policy types allowable for sale by travel agents pursuant to Section 1753.

(Amended by Stats. 2009, Ch. 10, Sec. 14. Effective July 2, 2009.)

785.1. (a) (1) An insurance broker or agent shall not participate in, be associated with, or employ any party that participates in, or is associated with, the origination of a reverse mortgage, unless the insurance agent or broker maintains procedural safeguards designed to ensure that the agent or broker transacting insurance has no direct financial incentive to refer the policyholder or prospective policyholder to a reverse mortgage lender.

(2) Except as provided in subdivision (b), individuals transacting insurance shall not receive compensation, commission, or direct incentive for providing reverse mortgage borrowers with a noncasualty insurance product that is connected to or a result of the reverse mortgage.

(b) This section does not prevent an agent or broker from offering title insurance, hazard, flood, or other peril insurance, or other similar products that are customary and normal under a reverse mortgage loan.

(Added by Stats. 2011, Ch. 223, Sec. 1. Effective January 1, 2012.)

785.4. (a) It shall be unlawful for any insurance agent who is not licensed as an attorney to deliver to a person

who is 65 years of age or older, a living trust or other legal document, other than an insurance contract or other insurance product document, if a purpose of the delivery is to sell an insurance product.

(b) It shall be unlawful for any insurance agent who is licensed as an attorney to deliver to a person who is 65 years of age or older, a living trust or other legal document, other than an insurance contract or other insurance product document, unless the insurance agent complies with Section 6175.3 of the Business and Professions Code.

(Added by Stats. 2012, Ch. 653, Sec. 2. Effective January 1, 2013.)

785.5. An insurance broker or agent shall not participate in, be associated with, or employ any party that participates in, or is associated with, obtaining veterans benefits for a senior, unless the insurance agent or broker maintains procedural safeguards designed to ensure that the agent or broker transacting insurance has no direct financial incentive to refer the policyholder, or prospective policyholder, to any veterans benefits program offered through the government.

(Added by Stats. 2012, Ch. 222, Sec. 1. Effective January 1, 2013.)

786. All disability insurance and life insurance policies and certificates offered for sale to individuals age 65 or older in California shall provide an examination period of 30 days after the receipt of the policy or certificate for purposes of review of the contract, at which time the applicant may return the contract. The return shall void the policy or certificate from the beginning, and the parties shall be in the same position as if no contract had been issued. All premiums paid and any policy or membership fee shall be fully refunded to the applicant by the insurer or entity in a timely manner.

(a) For the purposes of this section a timely manner shall be no later than 30 days after the insurer or entity issuing the policy or certificate receives the returned policy or certificate.

(b) If the insurer or entity issuing the policy or certificate fails to refund all of the premiums paid, in a timely manner, then the applicant shall receive interest on the paid premium at the legal rate of interest on judgments as provided in Section 685.010 of the Code of Civil Procedure. The interest shall be paid from the date the insurer or entity received the returned policy or certificate.

(c) Each policy or certificate shall have a notice prominently printed in no less than 10-point uppercase type, on the cover page of the policy or certificate and the outline of coverage, stating that the applicant has the right to return the policy or certificate within 30 days after its receipt via regular mail, and to have the full premium refunded.

(d) In the event of any conflict between this section and Section 10127.10 with respect to life insurance, the provisions of Section 10127.10 shall prevail.

(Amended by Stats. 2003, Ch. 546, Sec. 2. Effective January 1, 2004.)

786.5. (a) All brokers, agents, or other entities offering a contract of disability insurance to persons 65 years of age or older in this state shall provide the prospective insured with a full and accurate written comparison with existing health coverage, and shall explain the relationship of the proposed coverage to any existing health benefits provided by Medicare, Medi-Cal, or any other health benefits available to the applicant. The written comparison shall be maintained in accordance with Section 10508.5. Disability insurers marketing through direct response to persons 65 years of age or older shall include in the application form questions to ascertain whether the prospective insured is currently 65 years of age or older, and whether the prospective insured is covered by Medi-Cal or a Medicare supplement policy. These direct response insurers shall provide the required comparison as early in the transaction as possible, but not later than the delivery of the insurance contract.

(b) The commissioner may prescribe a standard comparison form and an informational brochure that shall be distributed to every prospective insured at the time insurance is offered for sale by an agent, broker, or other producer. In the case of a transportation ticket policy, the informational brochures shall be delivered to the prospective insured not later than delivery of the insurance contract. Disability insurers marketing through direct response to persons 65 years of age or older shall provide the informational brochure as early in the transaction as possible, but not later than the delivery of the insurance contract.

(c) The amendments to this section made by Assembly Bill 1178 of the 2001–02 Regular Session shall become operative January 1, 2002.

(Amended by Stats. 2001, Ch. 51, Sec. 2. Effective July 9, 2001. Amended version operative January 1, 2002, pursuant to new subdivision (c) (in force July 9, 2001).)

787. Any advertisement or other device designed to produce leads based on a response from a potential insured that is directed towards persons 65 years of age or older shall prominently disclose that an agent may contact the applicant if that is the fact. In addition, an agent who makes contact with a person as a result of acquiring that person's name from a lead generating device shall disclose that fact in the initial contact with the person.

(a) An insurer, agent, broker, solicitor, or other person or other entity shall not solicit persons 65 years of age and older in this state for the purchase of disability insurance, life insurance, or annuities through the use of a true name or fictitious name that is deceptive or misleading with regard to the status, character, or proprietary or representative capacity of the entity or person, or to the true purpose of the advertisement.

(b) For the purposes of this section, an advertisement includes envelopes, stationery, business cards, worksheets, questionnaires, or other materials designed to describe and encourage the purchase of a policy or certificate of disability insurance, life insurance, or an annuity, or to collect personal or financial information about a prospective insured or purchaser of an annuity.

(c) Advertisements shall not employ words, letters, initials, symbols, or other devices that are so similar to those used by governmental agencies, a nonprofit or charitable institution, veterans organization or agency, senior organization, or other insurer that they could have the capacity or tendency to mislead the public. Examples of misleading materials include, but are not limited to, those which imply any of the following:

(1) The advertised coverages are somehow provided by or are endorsed by any governmental agencies, nonprofit or charitable institutions, veterans organizations or agencies, or senior organizations.

(2) The advertiser is the same as, is connected with, or is endorsed by governmental agencies, nonprofit or charitable institutions, veterans organizations or agencies, or senior organizations.

(d) An advertisement may not use the name of a state or political subdivision thereof in a policy name or description.

(e) An advertisement may not use any name, service mark, slogan, symbol, or any device in any manner that implies that the insurer, or the policy or certificate advertised, or that any agency that may call upon the consumer in response to the advertisement, is connected with a governmental agency, such as the federal Social Security Administration or the United States Department of Veterans Affairs.

(f) An advertisement may not imply that the reader may lose a right, or privilege, or benefits under federal, state, or local law if he or she fails to respond to the advertisement.

(g) An insurer, agent, broker, or other entity may not use an address so as to mislead or deceive as to the true identity, location, or licensing status of the insurer, agent, broker, or other entity.

(h) An insurer may not use, in the trade name of its insurance policy or certificate, any terminology or words so similar to the name of a governmental agency, governmental program, or veterans organization or agency as to have the capacity or the tendency to confuse, deceive, or mislead a prospective purchaser.

(i) All advertisements used by agents, producers, brokers, solicitors, or other persons for a policy of an insurer shall have written approval of the insurer before they may be used.

(j) An insurer, agent, broker, or other entity may not solicit a particular class by use of advertisements which state or imply that the occupational or other status as members of the class entitles them to reduced rates on a group or other basis when, in fact, the policy or certificate being advertised is sold on an individual basis at regular rates.

(k) In addition to any other prohibition on untrue, deceptive, or misleading advertisements, no advertisement for an event where insurance products will be offered for sale at, or as a result of, the event may use the terms "seminar," "class," "informational meeting," "benefits assistance," "qualification information," or substantially equivalent terms to characterize the purpose of the public gathering or event unless it adds the words "and insurance sales presentation" immediately following those terms in the same type size and font as those terms.

(l) Any advertisement for an event, presentation, seminar, workshop, or other public gathering regarding veterans' benefits or entitlements is required to comply with the requirements of paragraph (25) of subdivision (a) of Section 1770 of the Civil Code.

(Amended by Stats. 2012, Ch. 653, Sec. 3. Effective January 1, 2013.)

787.1. (a) The following definitions apply to this section:

(1) "Senior designation" means any degree, title, credential, certificate, certification, accreditation, or approval, that expresses or implies that a broker or agent possesses expertise, training, competence, honesty, or reliability

with regard to advising seniors in particular on finance, insurance, or risk management.

(2) “Use” means utilizing a word, phrase, acronym, or logo, in any oral or written communication from which a sale of insurance to a senior may directly or indirectly result, that states or suggests, alone or in context, that a broker or agent holds a senior designation.

(b) (1) A broker or agent may not use a senior designation unless all of the following conditions have been met:

(A) The broker or agent has been granted the right to use the senior designation by the organization that issues the senior designation, and the broker or agent is currently authorized by the organization to use the designation.

(B) The senior designation has been approved by the commissioner for use by brokers and agents in the sale of insurance to seniors.

(C) The broker or agent has been licensed for at least four years in any state or United States territory to sell the types of insurance with which the designation is used.

(2) A broker or agent may not use a senior designation in a manner that misleads a person as to the significance of the senior designation. Each time a broker or agent uses a senior designation in a writing, the writing shall also contain the words “California” or “CA” next to “Insurance Agent” or “Insurance Broker Agent” and “License,” and these words shall be located immediately prior to the broker’s license number or the agent’s license number, in type that is in the same font and at least the same size as the type used for the senior designation. The requirements set forth in this subdivision are in addition to the requirements of Section 1725.5 and shall apply regardless of whether the broker or agent is an insurance agent, as defined in Section 1621. For purposes of this paragraph, “writing” means business cards, written price quotations, and print advertisements distributed exclusively in this state.

(c) The commissioner shall approve a senior designation only if the organization that issues the designation satisfies all of the following requirements with respect to the designation:

(1) The organization has applied for approval on a form prescribed by the commissioner.

(A) The department may require the filing of any supplementary documents and declarations it deems necessary to determine whether the prerequisites for approval have been met.

(B) Before or after approval, an organization shall notify the department in writing within 45 days following any material change in information recorded on the application form or in declarations or documents submitted along with it or in response to a department request.

(2) The designation is accredited by the National Commission for Certifying Agencies, or the organization or the designation is accredited by an agency that is on the United States Department of Education’s list entitled “Accrediting Agencies Recognized for Title IV Purposes” and it is established to the satisfaction of the commissioner that the agency is qualified to accredit an organization or designation involved with financial services provided to seniors.

(3) The organization requires California candidates for the designation to demonstrate superior expertise in advising seniors in particular in finance, insurance, or risk management by passing examinations that are based on applicants with no prior insurance education or experience completing at least 75 hours of study covering at least the following topics: aspects of aging, health care coverage, long-term care insurance, financial planning for retirement, investments, estate planning, and ethics. Textbooks or other study materials may use chapter and subchapter titles that differ from those general topics as long as the essential content is the same. No part of the examinations, textbooks, or other study materials may concern techniques on how to increase the amount of insurance or financial products one sells, or recommend the selling of products offered by specific companies.

(d) (1) In determining whether to approve a senior designation for use in the sale of insurance to seniors, the commissioner shall also ensure that the organization that issues the senior designation fulfills the following:

(A) Is exclusively an educational or certification organization, and is not directly or indirectly, through an affiliate or partner, involved in selling insurance, nor receives any compensation directly or indirectly from any sale of insurance, other than the receipt of charitable gifts by a nonprofit institution.

(B) Maintains standards and procedures for disciplining its designees for improper or unethical conduct, as established by proven complaints or by disciplinary action by a government licensing agency or a quasi-governmental licensing and regulatory organization. The standards and procedures shall include, at a minimum:

(i) A written procedure to receive, log, and conduct a preliminary review of complaints alleging improper, illegal, or unethical conduct.

(ii) Written standards for determining when a complaint warrants further investigation into the merits of the allegations contained therein.

(iii) Written standards and procedures to ensure that, once a complaint is determined to warrant further investigation, the investigation is diligently conducted.

(iv) Written standards for determining when to file disciplinary charges based on the results of an investigation.

(v) Written standards and procedures to ensure due process in the adjudication of disciplinary charges by adjudicators who are fair, knowledgeable, and otherwise qualified.

(vi) Written standards and procedures for the imposition of appropriate sanctions, including, when warranted, revocation of the designation.

(C) Maintains a code of ethics for its California designees consistent with that of one of the designations recited in Section 1749.4.

(e) (1) A word, phrase, acronym, or logo shall be deemed a senior designation if it contains the word “senior,” “Medicare,” “Medi-Cal,” “retire,” “mature,” “gerontology,” or “elder,” or any variation or synonym of one of these words within several words of the word “certified,” “chartered,” “registered,” “adviser,” “specialist,” “consultant,” “agent,” “broker,” “insurance,” “planner,” “professional,” “enrolled,” “accredited,” “analyst,” or “fellow,” or any variation or synonym of one of these words. A word, phrase, acronym, or logo may constitute a senior designation if it meets the definition in paragraph (1) of subdivision (a) regardless of whether it contains one of the words recited in this subdivision.

(2) A word, phrase, acronym, or logo shall not constitute a senior designation if it is a job title or description of an employee of a governmental entity, or of an organization with a contract with that governmental entity to provide free counseling to seniors.

(3) No exemption exists under this section for use of a senior designation that constitutes a job title or description or part of a job title or description, except as provided in paragraph (2).

(4) An advanced academic degree, such as a Ph.D., M.B.A., or M.S., may be used without compliance with subdivision (d), if the degree was awarded by an institution of higher education that has been accredited by an organization that is on the United States Department of Education’s list entitled “Accrediting Agencies Recognized for Title IV Purposes.”

(f) A violation of subdivision (b) by a broker or agent shall be grounds for suspension or revocation of the broker’s or agent’s license pursuant to Sections 1668 and 1738. Such a violation also shall be grounds for a cease and desist order and monetary penalty pursuant to Section 12921.8, as if the broker or agent had acted in a capacity for which a license was required but not possessed.

(g) Any person who grants to a California resident the right to use a senior designation that has not been approved by the commissioner, without reasonably attempting to determine whether California is one of the designee’s residences, shall be subject to a cease and desist order and monetary penalty pursuant to Section 12921.8, as if the person had acted in a capacity for which a license was required but not possessed.

(h) The disciplinary and remedial authority recited in this subdivision shall be in addition to any other disciplinary and remedial authority included in this code.

(i) Notwithstanding any other provision of this code, the criteria in Sections 1668 and 1668.5 apply to an organization that issues a senior designation, and the commissioner may deny or rescind approval of an organization issuing a senior designation based on that criteria.

(j) The commissioner shall maintain a list of senior designations approved pursuant to subdivisions (c), (d), and (e) and shall publish the current list on the Internet Web site of the Department of Insurance.

(k) This section shall apply to all types of insurance, including those listed in paragraphs (1) and (2) of subdivision (c) of Section 785, except those listed in paragraphs (3) to (7), inclusive, and paragraph (9) of subdivision (c) of Section 785 and subdivision (d) of Section 785.

(l) The commissioner may, upon receipt of a petition from an organization, issue written confirmation that a designation issued by that organization is exempt from the requirement of approval pursuant to this section. The commissioner may issue confirmation if the designation, according to its title or curriculum, or in its actual use, concerns almost exclusively subject matters other than insurance or financial services sold to seniors in particular.

(m) (1) The commissioner may rescind approval of a designation whenever there has been a material change in

the management or operation of the organization that issues the designation, or in the procedures or criteria for issuance of the designation, such that if the organization were to apply for approval of the designation subsequent to the change, approval would be denied.

(2) Any rescission of the approval of a designation shall be after notice and a hearing conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, as if the approval were a license, and the commissioner shall have all of the powers granted therein.

(Amended by Stats. 2011, Ch. 296, Sec. 182. Effective January 1, 2012.)

788. An insurer, agent, broker, or other person engaged in the transaction of insurance shall not knowingly recommend for sale, or sell, disability insurance providing health benefits directly to a Medi-Cal beneficiary who is age 65 or older. For disability insurance providing health benefits sold to a person age 65 or older, the application or other supplemental record signed by the applicant shall contain a question designed to determine if the applicant is receiving Medi-Cal benefits.

(Added by Stats. 1990, Ch. 1454, Sec. 1.)

788.5. No insurer, broker, agent, or other person shall cause an insured aged 65 years or older to replace a disability insurance policy or certificate unnecessarily.

(a) No insurer, broker, agent, or other entity within the jurisdiction of the department shall promote or cause overloading of disability coverage to persons aged 65 years or older. For purposes of this section, “overloading” means possession by an insured of functionally identical coverages that overlap or duplicate benefits to the extent that a reasonable person would not consider their ownership to be cost-effective.

(b) It shall be presumed that the sale of disability insurance that is the subject of this article, sold to a person aged 65 years or older, is overloading, as defined in subdivision (a), if the insured is already covered by Medicare Parts A and B as well as one Medicare supplement policy, certificate, or contract and coverage for excess charges under Part B.

(c) The application for disability insurance for a person age 65 years or older shall contain a question or questions designed to elicit information regarding all other existing health and disability coverage in force by type and company.

(Amended by Stats. 1991, Ch. 1116, Sec. 3.)

788.7. No insurer, broker, agent, or other person shall knowingly recommend for purchase or sell disability insurance to a person age 65 or older which results in the insured having coverage, for medical benefits, for more than 100 percent of actual medical expenses.

(Added by Stats. 1990, Ch. 1454, Sec. 1.)

789. (a) The commissioner shall have the administrative authority to assess penalties against insurers, brokers, agents, and other entities engaged in the transaction of insurance or any other person or entity for violations of this article.

(b) Upon a showing of a violation of this article in any civil action, a court may also assess the penalties prescribed in this chapter.

(c) Whenever the commissioner has reasonable cause to believe or determines after a public hearing that any insurer, agent, broker, or other person or entity engaged in the transaction of insurance, has violated this article the commissioner shall make and serve upon the insurer, broker, agent, or other person or entity a notice of hearing. The notice shall state the commissioner’s intent to assess the administrative penalties, the time and place of the hearing, and the conduct, condition or ground upon which the commissioner is holding the hearing, and assessing the penalties. The hearing shall occur within 30 days after the notice is served. Within 30 days after the hearing the commissioner shall issue an order specifying the amount of the penalties to be paid. The penalties resulting from the hearing shall be paid to the Insurance Fund.

(d) The powers vested in the commissioner by this section shall be in addition to any and all powers and remedies vested in the commissioner by law.

(e) Actions for injunctive relief, penalties specified in Section 789.3, damages, restitution, and all other remedies in law, may be brought in superior court by the Attorney General, district attorney, or city attorney on behalf of

the people of California. The court shall award reasonable attorney's fees and court costs to the prevailing plaintiff who establishes a violation of this article.

(Added by Stats. 1990, Ch. 1454, Sec. 1.)

789.3. (a) Any broker, agent, or other person or other entity engaged in the transactions of insurance, other than an insurer, who violates this article is liable for an administrative penalty of no less than one thousand dollars ($1,000) for the first violation.

(b) Any broker, agent, other person, or other entity engaged in the business of insurance, other than an insurer, who engages in practices prohibited by this article a second or subsequent time or who commits a knowing violation of this article, is liable for an administrative penalty of no less than five thousand dollars ($5,000) and no more than fifty thousand dollars ($50,000) for each violation.

(c) If the commissioner brings an action against a licensee pursuant to subdivision (a) or (b) and determines that the licensee may reasonably be expected to cause significant harm to seniors, the commissioner may suspend his or her license pending the outcome of the hearing described in subdivision (c) of Section 789.

(d) Any insurer who violates this article is liable for an administrative penalty of ten thousand dollars ($10,000) for the first violation.

(e) Any insurer who violates this article with a frequency as to indicate a general business practice or commits a knowing violation of this article, is liable for an administrative penalty of no less than thirty thousand dollars ($30,000) and no more than three hundred thousand dollars ($300,000) for each violation.

(f) The commissioner may require rescission of any contract found to have been marketed, offered, or issued in violation of this article.

(Amended by Stats. 2003, Ch. 546, Sec. 3. Effective January 1, 2004.)

789.5. If any provision of this article or the application thereof to any person or circumstances is held invalid, that invalidity shall not affect other provisions or applications of the article which can be given effect, without the invalid provision or application, and to this end the provisions of the article are severable.

(Added by Stats. 1990, Ch. 1454, Sec. 1.)

789.6. (a) Insurance policies or certificates of disability insurance sold to persons age 65 or older shall return to policyholders or certificate holders benefits that have a minimum loss ratio of 60 percent for individual policies and 75 percent for group policies. The loss ratio shall be on the basis of incurred claims experience and earned premiums.

(b) The commissioner shall require every entity providing insurance policies or certificates of disability insurance sold to persons age 65 or older in this state to maintain detailed experience data for policies and certificates subject to this section and require them to make an annual filing with the commissioner disclosing the loss ratio for each policy form or certificate subject to this section. The annual filing shall, at a minimum, include rates, rating schedules, and supporting documentation including ratios of incurred losses to earned premiums by number of years of policy duration. That information shall demonstrate that each policy form or certificate is in compliance with the applicable loss ratio standards.

(c) The commissioner shall assure that reserves are reasonable and based on sound actuarial principles with respect to the aggregate dollar amount of reserves for claims that are incurred but not yet paid, and for claims that are incurred but not yet reported.

(d) Policy forms or certificates shall be deemed to comply with the purposes of this section if the expected losses in relation to premiums over the entire period for which the policy form or certificate is rated comply with the requirements of this section and either of the following applies:

(1) For policies or certificates that have been in force for three years or more, for the most recent year the ratio of incurred losses to earned premiums is greater than or equal to the minimum loss ratios established by this section.

(2) For policies or certificates that have been in force for three years or less, the expected third year loss ratio can be demonstrated to be greater than or equal to the minimum loss ratio.

(e) If the annual filing or other information received by the commissioner indicates that the actual loss ratio for a policy or certificate is less than the minimum loss ratio established by this section, the commissioner shall require

that the insurer or entity providing the insurance file and implement a corrective plan. This plan shall include the utilization of premium reductions, dividends, benefit increases, or any combination of these or other methods so that the minimum loss ratio can be reasonably expected to be achieved. Any corrective plan shall be reviewed and approved by the commissioner prior to implementation.

(f) If, in the opinion of the commissioner, a policy's or certificate's failure to meet the minimum loss ratio requirements is due to unusual reserve fluctuations, economic conditions, or other nonrecurring conditions, the commissioner may exempt the policy or certificate from the need for a corrective plan for that year. Any exemption shall be in writing and shall specify the reasons for the granting of the exemption.

(g) If the insurer or other entity providing disability insurance to persons 65 years of age or older in this state fails to file and implement a corrective plan in a timely manner, the commissioner shall withdraw approval of the policy or certificate according to the procedures set forth in Section 10293. This remedy is in addition to any remedy available in that section or under other laws of this state. Any report, plan, exemption, or other document prepared pursuant to this section shall be accessible to the public as a public record.

(h) The commissioner may adopt regulations to implement or administer this article.

(Amended by Stats. 1992, Ch. 427, Sec. 111. Effective January 1, 1993.)

789.7. (a) Sales of disability insurance regulated by this article, as well as Medicare supplement insurance and long-term care insurance sold to persons aged 65 years or older, shall be registered by the insurer with the commissioner. The commissioner shall provide facilities for the computerized recordkeeping of all registered policies and certificates. The commissioner shall adopt regulations to implement and administer registration pursuant to this section. Regulations shall include, but need not be limited to, a system for assessing insurers in accordance with each insurer's market share in order to finance the cost of registration, an appropriate method and schedule for the filing of data with the commissioner, the content and format required for each filing in accordance with subdivision (d), appropriate sanctions for failure to comply with this section or with regulations promulgated under this section, and criteria for releasing the registered information to parties outside the department.

(b) Access to the registered information, including the identity of policyholders, shall be strictly limited to the department, with the exception that the Attorney General, a district attorney, or city attorney may be granted access upon request for the purpose of investigating or prosecuting suspected unlawful practices or for purposes of this article. The commissioner may, at his or her discretion, allow access to the registered information to the Health Insurance Counseling and Advocacy Program in the Department of Aging.

(c) Access to registered information in a purely statistical format, which neither identifies nor enables identification of a particular policyholder, may be released at the discretion of the commissioner to any party who demonstrates that the information will be used only for other than commercial purposes.

(d) The content of the filing shall contain no more than the following information:

(1) Policyholder's Medicare identification number or social security number. The policyholder's name shall be specifically excluded from the filing.

(2) A description of the policy as being Medicare supplemental insurance; long-term care insurance; or disability insurance.

(3) Date of sale.

(4) Date of lapse.

(5) Whether the policy is in force as of the date of the filing.

(6) The policy form number, if applicable.

(7) The name of any insurer, broker, agent, or other person engaged in the transaction of insurance who was responsible for the sale of the policy.

(Added by Stats. 1991, Ch. 1116, Sec. 5.)

789.8. (a) "Elder" for purposes of this section means any person residing in this state who is 65 years of age or older.

(b) If a life agent offers to sell to an elder any life insurance or annuity product, the life agent shall advise an elder

or elder's agent in writing that the sale or liquidation of any stock, bond, IRA, certificate of deposit, mutual fund, annuity, or other asset to fund the purchase of this product may have tax consequences, early withdrawal penalties, or other costs or penalties as a result of the sale or liquidation, and that the elder or elder's agent may wish to consult independent legal or financial advice before selling or liquidating any assets and prior to the purchase of any life or annuity products being solicited, offered for sale, or sold. This section does not apply to a credit life insurance product as defined in Section 779.2.

(c) A life agent who offers for sale or sells a financial product to an elder on the basis of the product's treatment under the Medi-Cal program may not negligently misrepresent the treatment of any asset under the statutes and rules and regulations of the Medi-Cal program, as it pertains to the determination of the elder's eligibility for any program of public assistance.

(d) A life agent who offers for sale or sells any financial product on the basis of its treatment under the Medi-Cal program shall provide, in writing, the following disclosure to the elder or the elder's agent:

"NOTICE REGARDING STANDARDS FOR MEDI-CAL ELIGIBILITY AND RECOVERY

If you or your spouse are considering purchasing a financial product based on its treatment under the Medi-Cal program, read this important message!

You or your spouse do not have to use up all of your savings before applying for Medi-Cal.

RECOVERY

An annuity purchased on or after September 1, 2004, shall be subject to recovery by the state upon the annuitant's death under the regulations of the Medi-Cal Recovery Program. Income derived from the annuity must be used to meet the annuitant's share of costs and, if the annuitant is married, the income derived from the annuity may impact the minimum monthly maintenance needs of the annuitant's community spouse. An annuity purchased by a community spouse on or after September 1, 2004, may also be subject to recovery if that spouse is the recipient of past or future Medi-Cal benefits.

UNMARRIED RESIDENT

An unmarried resident may be eligible for Medi-Cal benefits if he or she has less than (insert amount of individual's resource allowance) in countable resources.

The Medi-Cal recipient is allowed to keep from his or her monthly income a personal allowance of (insert amount of personal needs allowance) plus the amount of any health insurance premiums paid. The remainder of the monthly income is paid to the nursing facility as a monthly share of cost.

MARRIED RESIDENT

COMMUNITY SPOUSE RESOURCE ALLOWANCE: If one spouse lives in a nursing facility, and the other spouse does not live in a facility, the Medi-Cal program will pay some or all of the nursing facility costs as long as the couple together does not have more than (insert amount of community countable assets).

MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE: If a spouse is eligible for Medi-Cal payment of nursing facility costs, the spouse living at home is allowed to keep a monthly income of at least his or her individual monthly income or (insert amount of the minimum monthly maintenance needs allowance), whichever is greater.

FAIR HEARINGS AND COURT ORDERS

Under certain circumstances, an at-home spouse can obtain an order from an administrative law judge or court that will allow the at-home spouse to retain additional resources or income. The order may allow the couple to retain more than (insert amount of community spouse resource allowance plus individual's resource allowance) in countable resources. The order also may allow the at-home spouse to retain more than (insert amount of the monthly maintenance needs allowance) in monthly income.

REAL AND PERSONAL PROPERTY EXEMPTIONS

Many of your assets may already be exempt. Exempt means that the assets are not counted when determining eligibility for Medi-Cal.

REAL PROPERTY EXEMPTIONS

ONE PRINCIPAL RESIDENCE: One property used as a home is exempt. The home will remain exempt in determining eligibility if the applicant intends to return home someday.

The home also continues to be exempt if the applicant's spouse or dependent relative continues to live in it.

Money received from the sale of a home can be exempt for up to six months if the money is going to be used for the purchase of another home.

REAL PROPERTY USED IN A BUSINESS OR TRADE: Real estate used in a trade or business is exempt regardless of its equity value and whether it produces income.

PERSONAL PROPERTY AND OTHER EXEMPT ASSETS

IRAs, KEOGHs, AND OTHER WORK-RELATED PENSION PLANS: These funds are exempt if the family member whose name it is in does not want Medi-Cal. If held in the name of a person who wants Medi-Cal and payments of principal and interest are being received, the balance is considered unavailable and is not counted. It is not necessary to annuitize, convert to an annuity, or otherwise change the form of the assets in order for them to be unavailable.

PERSONAL PROPERTY USED IN A TRADE OR BUSINESS.

ONE MOTOR VEHICLE.

IRREVOCABLE BURIAL TRUSTS OR IRREVOCABLE PREPAID BURIAL CONTRACTS.

THERE MAY BE OTHER ASSETS THAT MAY BE EXEMPT.

This is only a brief description of the Medi-Cal eligibility rules. For more detailed information, you should call your county welfare department. Also, you are advised to contact a legal services program for seniors or an attorney who is not connected with the sale of this product.

I have read the above notice and have received a copy.

Dated: _____ Signature: _____"

The statement required in this subdivision shall be printed in at least 12-point type, shall be clearly separate from any other document or writing, and shall be signed by the prospective purchaser and that person's spouse, and legal representative, if any.

(e) The State Department of Health Services shall update this form to ensure consistency with state and federal law and make the disclosure available to agents and brokers through its Internet Web site.

(f) Nothing in this section allows or is intended to allow the unlawful practice of law.

(g) Subdivisions (b) and (d) shall become operative on July 1, 2001.

(Amended by Stats. 2006, Ch. 405, Sec. 1.5. Effective September 22, 2006. Note: Operation of amendment was not delayed by Sec. 14 of Ch. 405.)

789.9. (a) In addition to any other reasons that a sale of an individual annuity to a senior may violate any provision of law, an annuity shall not be sold to a senior in any of the following circumstances:

(1) The senior's purpose in purchasing the annuity is to affect Medi-Cal eligibility and either of the following is true:

(A) The purchaser's assets are equal to or less than the community spouse resource allowance established annually by the State Department of Health Services pursuant to the Medi-Cal Act (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code).

(B) The senior would otherwise qualify for Medi-Cal.

(2) The senior's purpose in purchasing the annuity is to affect Medi-Cal eligibility and, after the purchase of the annuity, the senior or the senior's spouse would not qualify for Medi-Cal.

(b) In the event that a fixed annuity specified in subdivision (a) is issued to a senior, the issuer shall rescind the contract and refund to the purchaser all premiums, fees, any interest earned under the terms of the contract, and costs paid for the annuity. This remedy shall be in addition to any other remedy that may be available.

(Added by Stats. 2003, Ch. 547, Sec. 2. Effective January 1, 2004.)

789.10. (a) This section applies to the sale, offering for sale, or generation of leads for the sale of life insurance, including annuities, to senior insureds or prospective insureds by any person.

(b) A person who meets with a senior in the senior's home is required to deliver a notice in writing to the senior no less than 24 hours and no more than 14 days prior to that individual's initial meeting in the senior's home. If the senior has an existing insurance relationship with an agent and requests a meeting with the agent in the senior's home the same day, a notice shall be delivered to the senior prior to the meeting. The notice shall be a stand-alone document, with the appropriate information inserted and without any attachments. It shall be written in 16-point bold type and include all of the following, but no other, information:

(1) The agent's full name as it appears on his or her California insurance license.

(2) The agent's license number.

(3) The agent's mailing address and telephone number listed on his or her California insurance license.

(4) The following disclosure:

(A) "I am a licensed insurance agent. My purpose for coming to your home is to sell, discuss, and/or deliver one of the following [indicate all that apply]:

( ) Life insurance, including annuities.

( ) Other insurance products [specify]: _____.

(B) You have the right to have other persons present at the meeting, including family members, financial advisors, or attorneys.

(C) You have the right to end the meeting at any time.

(D) You have the right to contact the Department of Insurance for information, or to file a complaint. [The notice shall include the consumer assistance telephone numbers at the department]

(E) The following individuals will be coming to your home: [list all attendees, and insurance license information, if applicable]"

(c) Upon contacting the senior in the senior's home, the person shall, before making any statement other than a greeting, or asking the senior any other questions, state that the purpose of the contact is to talk about insurance, or to gather information for a followup visit to sell insurance, if that is the case, and state all of the following information:

(1) The name and titles of all persons arriving at the senior's home.

(2) The name of the insurer represented by the person, if known.

(d) Each person attending a meeting with a senior shall provide the senior with a business card or other written identification stating the person's name, business address, telephone number, and any insurance license number.

(e) The persons attending a meeting with a senior shall end all discussions and leave the home of the senior immediately after being asked to leave by the senior.

(f) A person may not solicit a sale or order for the sale of an annuity or life insurance policy at the residence of a senior, in person or by telephone, by using any plan, scheme, or ruse that misrepresents the true status or mission of the contact.

(Amended by Stats. 2012, Ch. 653, Sec. 4. Effective January 1, 2013.)

Up ^

INSURANCE CODE - INS

DIVISION 1. GENERAL RULES GOVERNING INSURANCE [100. - 1879.8.] *(Division 1 enacted by Stats. 1935, Ch. 145.)*

PART 2. THE BUSINESS OF INSURANCE [680. - 1879.8.] *(Part 2 enacted by Stats. 1935, Ch. 145.)*

CHAPTER 1. General Regulations [680. - 1113.] *(Chapter 1 enacted by Stats. 1935, Ch. 145.)*

ARTICLE 6.5. Unfair Practices [790. - 790.15.] *(Article 6.5 added by Stats. 1959, Ch. 1737.)*

790. The purpose of this article 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, Seventy-ninth Congress), by defining, or providing for the determination of, all such practices in this State which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

(Added by Stats. 1959, Ch. 1737.)

790.01. This article applies to reciprocal and interinsurance exchanges, Lloyds insurers, fraternal benefit societies, fraternal fire insurers, grants and annuities societies, insurers holding certificates of exemptions, motor clubs, nonprofit hospital associations, life agents, broker-agents, surplus line brokers and special lines surplus line brokers as well as all other persons engaged in the business of insurance.

(Amended by Stats. 1990, Ch. 1420, Sec. 2. Operative January 1, 1992, by Sec. 77 of Ch. 1420.)

790.02. No person shall engage in this State in any trade practice which is defined in this article as, or determined pursuant to this article to be, an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.

(Added by Stats. 1959, Ch. 1737.)

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

(a) 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 the policyholder to lapse, forfeit, or surrender his or her insurance.

(b) Making or disseminating or causing to be made or disseminated before the public in this state, in any newspaper or other publication, or any advertising device, or by public outcry or proclamation, or in any other manner or means whatsoever, any 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 or her insurance business, which is untrue, deceptive, or misleading, and which is known, or which by the exercise of reasonable care should be known, to be untrue, deceptive, or misleading.

(c) 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.

(d) 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.

(e) 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 the insurer is required by law to report, or who has authority by law to examine into its condition or into any of its affairs, or, with like intent, willfully omitting to make a true entry of any material fact pertaining to the business of the insurer in any book, report, or statement of the insurer.

(f) (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 the contract.

(2) This subdivision shall be interpreted, for any contract of ordinary life insurance or individual life annuity applied for and issued on or after January 1, 1981, to require differentials based upon the sex of the individual insured or annuitant in the rates or dividends or benefits, or any combination thereof. This requirement is satisfied if those differentials are substantially supported by valid pertinent data segregated by sex, including, but not limited to, mortality data segregated by sex.

(3) However, for any contract of ordinary life insurance or individual life annuity applied for and issued on or after January 1, 1981, but before the compliance date, in lieu of those differentials based on data segregated by sex, rates, or dividends or benefits, or any combination thereof, for ordinary life insurance or individual life annuity on a female life may be calculated as follows: (A) according to an age not less than three years nor more than six years younger than the actual age of the female insured or female annuitant, in the case of a contract of ordinary life insurance with a face value greater than five thousand dollars ($5,000) or a contract of individual life annuity; and (B) according to an age not more than six years younger than the actual age of the female insured, in the case of a contract of ordinary life insurance with a face value of five thousand dollars ($5,000) or less. “Compliance date” as used in this paragraph shall mean the date or dates established as the operative date or dates by future amendments to this code directing and authorizing life insurers to use a mortality table containing mortality data segregated by sex for the calculation of adjusted premiums and present values for nonforfeiture benefits and valuation reserves as specified in Sections 10163.1 and 10489.2 or successor sections.

(4) Notwithstanding the provisions of this subdivision, sex-based differentials in rates or dividends or benefits, or any combination thereof, shall not be required for (A) any contract of life insurance or life annuity issued pursuant to arrangements which may be considered terms, conditions, or privileges of employment as these terms are used in Title VII of the Civil Rights Act of 1964 (Public Law 88-352), as amended, and (B) tax sheltered annuities for employees of public schools or of tax-exempt organizations described in Section 501(c)(3) of the Internal Revenue Code.

(g) Making or disseminating, or causing to be made or disseminated, before the public in this state, in any newspaper or other publication, or any other advertising device, or by public outcry or proclamation, or in any other manner or means whatever, whether directly or by implication, any statement that a named insurer, or named insurers, are members of the California Insurance Guarantee Association, or insured against insolvency as defined in Section 119.5. This subdivision shall not be interpreted to prohibit any activity of the California Insurance Guarantee Association or the commissioner authorized, directly or by implication, by Article 14.2 (commencing with Section 1063).

(h) Knowingly committing or performing with such frequency as to indicate a general business practice any of the following unfair claims settlement practices:

(1) Misrepresenting to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.

(2) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.

(3) Failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.

(4) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss requirements have been completed and submitted by the insured.

(5) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.

(6) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by the insureds, when the insureds have made claims for amounts reasonably similar to the amounts ultimately recovered.

(7) Attempting to settle a claim by an insured for less than the amount to which a reasonable person would have believed he or she was entitled by reference to written or printed advertising material accompanying or made part of an application.

(8) Attempting to settle claims on the basis of an application that was altered without notice to, or knowledge or consent of, the insured, his or her representative, agent, or broker.

(9) Failing, after payment of a claim, to inform insureds or beneficiaries, upon request by them, of the coverage under which payment has been made.

(10) Making known to insureds or claimants a practice of the insurer of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

(11) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either, to submit a preliminary claim report, and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information.

(12) Failing to settle claims promptly, where liability has become apparent, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

(13) Failing to provide promptly a reasonable explanation of the basis relied on in the insurance policy, in relation to the facts or applicable law, for the denial of a claim or for the offer of a compromise settlement.

(14) Directly advising a claimant not to obtain the services of an attorney.

(15) Misleading a claimant as to the applicable statute of limitations.

(16) Delaying the payment or provision of hospital, medical, or surgical benefits for services provided with respect to acquired immune deficiency syndrome or AIDS-related complex for more than 60 days after the insurer has received a claim for those benefits, where the delay in claim payment is for the purpose of investigating whether the condition preexisted the coverage. However, this 60-day period shall not include any time during which the insurer is awaiting a response for relevant medical information from a health care provider.

(i) Canceling or refusing to renew a policy in violation of Section 676.10.

(j) Holding oneself out as representing, constituting, or otherwise providing services on behalf of the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code without a valid agreement with the California Health Benefit Exchange to engage in those activities.

(Amended by Stats. 2012, Ch. 876, Sec. 3. Effective January 1, 2013.)

790.031. The requirements of subdivision (b) of Section 790.034, and Sections 2071.1 and 10082.3 shall apply only to policies of residential property insurance as defined in Section 10087, policies and endorsements containing those coverages prescribed in Chapter 8.5 (commencing with Section 10081) of Part 1 of Division 2, policies issued by the California Earthquake Authority pursuant to Chapter 8.6 (commencing with Section 10089.5) of Part 1 of Division 2, policies and endorsements that insure against property damage and are issued to common interest developments or to associations managing common interest developments, as those terms are defined in Section 1351 of the Civil Code, and to policies issued pursuant to Section 120 that insure against property damage to residential units or contents thereof owned by one or more persons located in this state.

(Added by Stats. 2001, Ch. 583, Sec. 2. Effective January 1, 2002. Superseded on January 1, 2014; see amendment by Stats. 2012, Ch. 181.)

790.031. The requirements of subdivision (b) of Section 790.034, and Sections 2071.1 and 10082.3 shall apply only to policies of residential property insurance as defined in Section 10087, policies and endorsements containing those coverages prescribed in Chapter 8.5 (commencing with Section 10081) of Part 1 of Division 2, policies issued by the California Earthquake Authority pursuant to Chapter 8.6 (commencing with Section 10089.5) of Part 1 of Division 2, policies and endorsements that insure against property damage and are issued to common interest developments or to associations managing common interest developments, as those terms are defined in Sections 4080 and 4100 of the Civil Code, and to policies issued pursuant to Section 120 that insure against property damage to residential units or contents thereof owned by one or more persons located in this state.

(Amended by Stats. 2012, Ch. 181, Sec. 78. Effective January 1, 2013. Operative January 1, 2014, by Sec. 86 of Ch. 181.)

790.034. (a) Regulations adopted by the commissioner pursuant to this article that relate to the settlement of claims shall take into consideration settlement practices by classes of insurers.

(b) (1) Upon receiving notice of a claim, every insurer shall immediately, but no more than 15 calendar days after receipt of the claim, provide the insured with a legible reproduction of subdivisions (h) and (i) of Section 790.03 along with a written notice containing the following language in at least 10-point type:

"In addition to Section 790.03 of the Insurance Code, Fair Claims Settlement Practices Regulations govern how insurance claims must be processed in this state. These regulations are available at the Department of Insurance Internet Web site, www.insurance.ca.gov. You may also obtain a copy of this law and these regulations free of charge from this insurer."

(2) Every insurer shall provide, when requested orally or in writing by an insured, a legible reproduction of Section 790.03 of the Insurance Code and copies of Sections 2695.5, 2695.7, 2695.8, and 2695.9 of Subchapter 7.5 of Chapter 5 of Title 10 of the California Code of Regulations, unless the regulations are inapplicable to that class of insurer. This law and these regulations shall be provided to the insured within 15 calendar days of request.

(3) The provisions of this subdivision shall apply to all insurers except for those that are licensed pursuant to Chapter 1 (commencing with Section 12340) of Part 6 of Division 2, with respect to policies and endorsements described in Section 790.031.

(Amended by Stats. 2011, Ch. 240, Sec. 1. Effective January 1, 2012.)

790.035. (a) Any person who engages in any unfair method of competition or any unfair or deceptive act or practice defined in Section 790.03 is liable to the state for a civil penalty to be fixed by the commissioner, not to exceed five thousand dollars ($5,000) for each act, or, if the act or practice was willful, a civil penalty not to exceed ten thousand dollars ($10,000) for each act. The commissioner shall have the discretion to establish what constitutes an act. However, when the issuance, amendment, or servicing of a policy or endorsement is inadvertent, all of those acts shall be a single act for the purpose of this section.

(b) The penalty imposed by this section shall be imposed by and determined by the commissioner as provided by Section 790.05. The penalty imposed by this section is appealable by means of any remedy provided by Section 12940 or by Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(Added by Stats. 1989, Ch. 725, Sec. 1. Effective September 25, 1989.)

790.036. (a) It is an unfair and deceptive act or practice in the business of insurance for an insurer to advertise insurance that it will not sell.

(b) Nothing in this section shall be construed to prohibit any insurer from advertising insurance products for which it is licensed to sell in this state where the product is not available for sale so long as the unavailability is disclosed in the advertisement.

(c) A violation of this section is subject to the sanctions provided for by this article.

(d) An intentional violation of this section is a misdemeanor punishable by a fine not exceeding ten thousand dollars ($10,000).

(e) This section does not apply to any insurer that refuses to sell a policy of insurance on the basis of its underwriting guidelines.

(f) This section does not apply to advertisements by an insurer where the advertisements are broadcast and originate from outside this state. As used in this subdivision, "broadcast" includes electronic media, television, and radio. As used in this subdivision, "originate from outside this state" includes cable transmittal of programs broadcast by stations located outside California.

(Added by Stats. 1989, Ch. 992, Sec. 1.)

790.037. (a) It is an unfair business practice for a health insurance agent or broker to sell, solicit, or negotiate the purchase of health insurance by any of the following methods:

(1) The use of a marketing technique known as cold lead advertising when marketing a Medicare product. As used in this section, "cold lead advertising" means making use directly or indirectly of a method of marketing that fails to disclose in a conspicuous manner that a purpose of the marketing is health insurance sales solicitation and that contact will be made by a health insurance agent or broker.

(2) The use of an appointment that was made to discuss a particular Medicare product or to solicit the sale of a particular Medicare product in order to solicit the sale of another Medicare product or other health insurance products, unless the consumer specifically agrees in advance of the appointment to discuss that other Medicare product or other types of health insurance products during the same appointment.

(b) As used in this section, "Medicare product" includes Medicare Parts A, B, C, and D, and Medicare supplement plans.

(Amended by Stats. 2009, Ch. 140, Sec. 126. Effective January 1, 2010.)

790.04. The commissioner shall have power to examine and investigate into the affairs of every person engaged in the business of insurance in the 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 790.03 or determined pursuant to this article to be an unfair method of competition or an unfair or deceptive practice in the business of insurance. Such investigation may be conducted pursuant to Article 2 (commencing at Section 11180) of Chapter 2, Part 1, Division 3, Title 2 of the Government Code.

(Added by Stats. 1959, Ch. 1737.)

790.05. Whenever the commissioner shall have reason to believe that a 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 790.03, and that a proceeding by the commissioner in respect thereto would be to the interest of the public, he or she shall issue and serve upon that person an order to show cause containing a statement of the charges in that respect, a statement of that person's potential liability under Section 790.035, and a notice of a hearing thereon to be held at a time and place fixed therein, which shall not be less than 30 days after the service thereof, for the purpose of determining whether the commissioner should issue an order to that person to, pay the penalty imposed by Section 790.035, and to cease and desist those methods, acts, or practices or any of them.

If the charges or any of them are found to be justified the commissioner shall issue and cause to be served upon that person an order requiring that person to pay the penalty imposed by Section 790.035 and to cease and desist from engaging in those methods, acts, or practices found to be unfair or deceptive.

The hearing shall be conducted in accordance with the Administrative Procedure Act, Chapter 5 (commencing at Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, except that the hearings may be conducted by an administrative law judge in the administrative law bureau when the proceedings involve a common question of law or fact with another proceeding arising under other Insurance Code sections that may be conducted by administrative law bureau administrative law judges. The commissioner and the appointed administrative law judge shall have all the powers granted under the Administrative Procedure Act.

The person shall be entitled to have the proceedings and the order reviewed by means of any remedy provided by Section 12940 of this code or by the Administrative Procedure Act.

(Amended by Stats. 2002, Ch. 709, Sec. 2. Effective January 1, 2003.)

790.06. (a) 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 the business that is not defined in Section 790.03, and that the method is unfair or that the act or practice is unfair or deceptive and that a proceeding by him or her in respect thereto would be in the interest of the public, he or she may issue and serve upon that person an order to show cause containing a statement of the methods, acts or practices alleged to be unfair or deceptive and a notice of hearing thereon to be held at a time and place fixed therein, which shall not be less than 30 days after the service thereof, for the purpose of determining whether the alleged methods, acts or practices or any of them should be declared to be unfair or deceptive within the meaning of this article. The order shall specify the reason why the method of competition is alleged to be unfair or the act or practice is alleged to be unfair or deceptive.

The hearings provided by this section shall be conducted in accordance with the Administrative Procedure Act

(Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code), except that the hearings may be conducted by an administrative law judge in the administrative law bureau when the proceedings involve a common question of law or fact with another proceeding arising under other Insurance Code sections that may be conducted by administrative law bureau administrative law judges. The commissioner and the appointed administrative law judge shall have all the powers granted under the Administrative Procedure Act. If the alleged methods, acts, or practices or any of them are found to be unfair or deceptive within the meaning of this article the commissioner shall issue and service upon that person his or her written report so declaring.

(b) If the report charges a violation of this article and if the method of competition, act or practice has not been discontinued, the commissioner may, through the Attorney General of this state, at any time after 30 days after the service of the report cause a petition to be filed in the superior court of this state within the county wherein the person resides or has his or her principal place of business, to enjoin and restrain the person from engaging in the 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 any writs as are ancillary to its jurisdiction or are necessary in its judgment to prevent injury to the public pendente lite.

(c) A transcript of the proceedings before the commissioner, including all evidence taken and the report and findings shall be filed with the 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 the additional evidence is material and there were reasonable grounds for the failure to adduce the evidence in the proceeding before the commissioner, the court may order the additional evidence to be taken before the commissioner and to be adduced upon the hearing in the manner and upon the terms and conditions as to the court may seem proper. The commissioner may modify his or her findings of fact or make new findings by reason of the additional evidence so taken, and shall file modified or new findings with the return of the additional evidence.

(d) 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 the weight of the evidence, it shall issue its order enjoining and restraining the continuance of the method of competition, act or practice.

(Amended by Stats. 2002, Ch. 709, Sec. 3. Effective January 1, 2003.)

790.07. Whenever the commissioner shall have reason to believe that any person has violated a cease and desist order issued pursuant to Section 790.05 or a court order issued pursuant to Section 790.06, after the order has become final, and while the order is still in effect, the commissioner may, after a hearing at which it is determined that the violation was committed, order that person to forfeit and pay to the State of California a sum not to exceed five thousand dollars ($5,000) plus any penalty due under Section 790.05, which may be recovered in a civil action, except that, if the violation is found to be willful, the amount of the penalty may be a sum not to exceed fifty-five thousand dollars ($55,000) plus the penalty due under Section 790.05.

For the purposes of this section, the failure to pay any penalty imposed pursuant to Section 790.035 which has become final shall constitute a violation of the cease and desist order.

For any subsequent violation of the cease and desist order or of the court order or the order to pay the penalty, while the order is still in effect, the commissioner may, after hearing, suspend or revoke the license or certificate of that person for a period not exceeding one year; provided, however, no proceeding shall be based upon the subsequent violation unless the same was committed or continued after the date on which the order imposing the penalty pursuant to the preceding paragraph became final.

The hearings provided by this section shall be conducted in accordance with the Administrative Procedure Act, except that the hearings may be conducted by an administrative law judge in the administrative law bureau when the proceedings involve a common question of law or fact with another proceeding arising under other Insurance Code sections that may be conducted by administrative law bureau administrative law judges. The commissioner and the appointed administrative law judge shall have all the powers granted under the Administrative Procedure Act.

The person shall be entitled to have the proceedings and the order of the commissioner therein reviewed by means of any remedy provided by Section 12940 or by the Administrative Procedure Act.

(Amended by Stats. 2002, Ch. 709, Sec. 4. Effective January 1, 2003.)

790.08. The powers vested in the commissioner in this article shall be additional to any other powers to enforce any penalties, fines or forfeitures, denials, suspensions or revocations of licenses or certificates authorized by law

with respect to the methods, acts and practices hereby declared to be unfair or deceptive.

(Added by Stats. 1959, Ch. 1737.)

790.09. No order to cease and desist issued under this article directed to any person or subsequent administrative or judicial proceeding to enforce the same shall in any way relieve or absolve such person from any administrative action against the license or certificate of such person, civil liability or criminal penalty under the laws of this State arising out of the methods, acts or practices found unfair or deceptive.

(Added by Stats. 1959, Ch. 1737.)

790.10. The commissioner shall, from time to time as conditions warrant, after notice and public hearing, promulgate reasonable rules and regulations, and amendments and additions thereto, as are necessary to administer this article.

(Added by Stats. 1971, Ch. 975.)

790.15. (a) If an insurer or any affiliate of an insurer has failed to pay any valid claim from Holocaust survivors, the certificate of authority of the insurer shall be suspended until the insurer, or its affiliates, pays the claim or claims.

(b) As used in this section:

(1) “Holocaust survivor” means any person who is the beneficiary of an insurance policy, if the insurance policy insured a person’s life, property, or other interest, and the insured person was killed, died, was displaced, or was otherwise a victim of persecution of Jewish and other peoples preceding and during World War II by Germany, its allies, or sympathizers.

(2) “Beneficiary” means any person or entity entitled to recover under any policy of insurance, including any named beneficiary, any heir of a named beneficiary, and any other person entitled to recover under the policy.

(3) “Claim” means any claim submitted by a Holocaust survivor or other beneficiary arising under an insurance policy for any loss or damage caused by or arising because of discriminatory practices or persecution by the Nazi-controlled German government or its allies, or by insurers that refused to pay claims because of a claim that policies of insurance or records were missing or confiscated because of actions by the Nazi-controlled German government or its agents or allies. Claim also includes any claim by Holocaust survivors or beneficiaries to collect proceeds from dowry or education policies or from annuities.

(4) An “affiliate” of, or person “affiliated” with, a specific person, means a person who directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

(5) “Control” includes the terms “controlling,” “controlled by,” and “under common control with,” and means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, more than 10 percent of the voting securities of any other person.

(c) An action to suspend a certificate of authority under this section shall be conducted in accordance with the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code), except that (1) if the Office of Administrative Hearings is unable to assign an administrative law judge to preside over a hearing that commences within 30 days of the filing of an accusation or order initiating an action under this section, the administrative law judge may be appointed by the commissioner; and (2) if the commissioner determines that it is necessary to protect the interests of Holocaust survivors, he or she may issue an order of suspension pursuant to this section prior to holding a hearing.

(d) If the commissioner issues an order pursuant to paragraph (2) of subdivision (c), he or she shall immediately issue and serve upon the insurer a statement of reasons for the immediate action, as well as a copy of the accusation or order containing the allegations that support the order. Any order issued pursuant to this subdivision shall include a notice stating the time and place of a hearing on the order, which shall not be less than 20, nor more than 30 days after the order is served.

(e) When considering an action to suspend a certificate of authority under this section, the commissioner shall include consideration of whether the insurer has participated in good faith in an international commission on Holocaust survivor insurance claims, and whether the commission is making meaningful and expeditious progress toward paying claims to survivors and righting the historic wrong done to Holocaust victims.

(Added by Stats. 1998, Ch. 963, Sec. 2. Effective September 29, 1998.)