WEST VIRGINIA LEGISLATURE

FIRST REGULAR SESSION, 1993

ENROLLED

House Bill No. 2632

(By Delegates Phillips, Bearer, Michael and J. White)

Passed ......................... April 10, 1993

In Effect Ninety Days After Passage
ENROLLED
COMMITTEE SUBSTITUTE
FOR
H. B. 2632
(By Delegates Phillips, Beane, Michael and L. White)

[Passed April 10, 1993: in effect ninety days from passage.]

AN ACT to amend and reenact article twenty-six-a, chapter thirty-three of the code of West Virginia, one thousand nine hundred thirty-one, as amended, relating to the life and health insurance guaranty association.

Be it enacted by the Legislature of West Virginia:

That article twenty-six-a, chapter thirty-three of the code of West Virginia, one thousand nine hundred thirty-one, as amended, be amended and reenacted to read as follows:

ARTICLE 26A. WEST VIRGINIA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT.


1 This article shall be known and may be cited as the
2 "West Virginia Life and Health Insurance Guaranty
3 Association Act."

§33-26A-2. Purpose of article and association of insurers.

1 (a) The purpose of this article is to protect, subject to
2 certain limitations, the persons specified in subsection
3 (a) of section three of this article against failure in the
4 performance of contractual obligations, under life and
5 health insurance policies and annuity contracts specified
6 in subsection (b) of section three of this article, because
of the impairment or insolvency of the member insurer
that issued the policies or contracts.

(b) To provide this protection, an association of
insurers is created to pay benefits and to continue
coverages as limited herein, and members of the
association are subject to assessment to provide funds to
carry out the purpose of this article.

§33-26A-3. Scope of article; policies and contracts cov-
ered; exclusions; extent of liability.

(a) This article shall provide coverage for the policies
and contracts specified in subsection (b) of this section:

(1) To persons who, regardless of where they reside,
are the beneficiaries, assignees or payees of the persons
covered under subdivision (2) below: Provided, That the
provisions of this subdivision shall not apply to nonres-
ident certificate holders under group policies or
contracts;

(2) To persons who are owners of or certificate holders
under such policies or contracts; or in the case of
unallocated annuity contracts, persons who are contract
holders, and who

(A) Are residents of the state; or

(B) Are not residents of this state, but only under all
of the following conditions:

(i) Such insurers which issued these policies or
contracts are domiciled in this state;

(ii) Such insurers never held a license or certificate
of authority in the state in which such person resides;

(iii) Such states have associations similar to the
association created by this article; and

(iv) The persons are not eligible for coverage by such
associations.

(b) Coverage as provided by this article shall be as
follows:

(1) This article shall provide coverage to the persons
specified in subsection (a) of this section for direct,
nongroup life, health, annuity and supplemental policies
or contracts, for certificates under direct group policies
and contracts, and for unallocated annuity contracts,
issued by member insurers, except as limited by this
article. Annuity contracts and certificates under group
annuity contracts include, but are not limited to,
guaranteed investment contracts, deposit administration
contracts, unallocated funding agreements, allocated
funding agreements, structured settlement agreements,
lottery contracts and any immediate or deferred annuity
contracts.

(2) This article shall not provide coverage for:

(A) Any portion of a policy or contract not guaranteed
by the insurer, or under which the risk is borne by the
policy or contract holder;

(B) Any policy or contract of reinsurance, unless
assumption certificates have been issued;

(C) Any portion of a policy or contract to the extent
that the rate of interest on which it is based:

(i) Averaged over the period of four years prior to the
date on which the association becomes obligated with
respect to such policy or contract, exceeds a rate of
interest determined by subtracting two percentage
points from Moody's Corporate Bond Yield Average
averaged for that same four-year period or for such
lesser period if the policy or contract was issued less
than four years before the association became obligated;
and

(ii) On and after the date on which the association
becomes obligated with respect to such policy or
contract, exceeds the rate of interest determined by
subtracting three percentage points from Moody's
Corporate Bond Yield Average as most recently
available;

(D) Any plan or program of an employer, association
or similar entity to provide life, health or annuity
benefits to its employees or members to the extent that
the plan or program is self-funded or uninsured,
including, but not limited to, benefits payable by an
employer, association or similar entity under:
(i) A multiple employer welfare arrangement as defined in section 514 of the Employee Retirement Income Security Act of 1974, as amended;
(ii) A minimum premium group insurance plan;
(iii) A stop-loss group insurance plan; or
(iv) An administrative services only contract;
(E) Any portion of a policy or contract to the extent that it provides dividends or experience rating credits, or provides that any fees or allowances be paid to any person, including the policy or contract holder, in connection with the service to or administration of the policy or contract;
(F) Any policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue the policy or contract in this state;
(G) Any unallocated annuity contract issued to an employee benefit plan protected under the federal pension benefit guaranty corporation; and
(H) Any portion of any unallocated annuity contract which is not issued to or in connection with a specific employee, union or association of natural persons benefit plan or a government lottery.
(c) The benefits for which the association may become liable shall in no event exceed the lesser of:
(1) The contractual obligations for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer; or
(2)(A) With respect to any one life, regardless of the number of policies or contracts:
(i) Three hundred thousand dollars in life insurance death benefits, but no more than one hundred thousand dollars in net cash surrender and net cash withdrawal values for life insurance;
(ii) One hundred thousand dollars in health insurance benefits, including any net cash surrender and net cash
withdrawal values;

(iii) One hundred thousand dollars in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;

(B) With respect to each individual participating in a governmental retirement plan established under section 401, 403(b) or 457 of the United States Internal Revenue Code covered by an unallocated annuity contract or the beneficiaries of each such individual if deceased, in the aggregate, one hundred fifty thousand dollars in present value annuity benefits, including net cash surrender and net cash withdrawal values: Provided, That in no event shall the association be liable to expend more than three hundred thousand dollars in the aggregate with respect to any one individual under paragraphs 2 (A) and (B) above;

(C) With respect to any one contract holder covered by any unallocated annuity contract not included in subsection (2) (B) of this section one million dollars in benefits, irrespective of the number of contracts held by that contract holder.

(d) The liability of the association is strictly limited by the express terms of the covered policies and contracts and by the provisions of this article and shall not in any event include any amount in excess of the applicable limits of coverage provided by the contracts or policies as limited by this article. The association is not liable for any extra contractual damages, claims, fees of any kind whatsoever, including interest, except as specifically provided by the terms of the policies or contracts as limited by this article.


This article shall be liberally construed to effect the purpose under section two of this article which shall constitute an aid and guide to interpretation.


As used in this article:

(1) “Account” means either of the two accounts created under section six of this article.
(2) "Association" means the West Virginia life and health insurance guaranty association created under section six of this article.

(3) "Commissioner" means the commissioner of insurance of this state.

(4) "Contractual obligation" means any obligation under a policy or contract or certificate under a group policy or contract, or portion thereof for which coverage is provided under section three of this article.

(5) "Covered policy" means any policy or contract within the scope of this article under section three of this article.

(6) "Impaired insurer" means a member insurer which, after the effective date of this article, is not an insolvent insurer, and (1) is deemed by the commissioner to be potentially unable to fulfill its contractual obligations or (2) is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(7) "Insolvent insurer" means a member insurer which, after the effective date of this article, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

(8) "Member insurer" means any insurer licensed or which holds a certificate of authority to transact in this state any kind of insurance for which coverage is provided under section three of this article, and includes any insurer whose license or certificate of authority in this state may have been suspended, revoked, not renewed or voluntarily withdrawn, and includes non-profit service corporations as defined in article twenty-four of this chapter and health care corporations as defined in article twenty-five of this chapter: Provided, That the term "member insurer" does not include:

(A) A health maintenance organization;

(B) A fraternal benefit society;

(C) A mandatory state polling plan;
(D) A mutual assessment company or any entity that operates on an assessment basis;

(E) An insurance exchange; or

(F) Any entity similar to any of the above.

(9) "Moody's Corporate Bond Yield Average" means the monthly average corporates as published by Moody's Investors Service, Inc., or any successor thereto.

(10) "Person" means any individual, corporation, partnership, association or voluntary organization.

(11) "Premiums" means amounts received on covered policies or contracts less premiums, considerations and deposits returned thereon, and less dividends and experience credits thereon. "Premiums" does not include any amounts received for any policies or contracts or for the portions of any policies or contracts for which coverage is not provided under subsection (b) of section three of this article, except that assessable premium shall not be reduced on account of paragraph (C), subdivision (2), subsection (b) of section three of this article relating to interest limitations and subdivision (2), subsection (c) of section three of this article relating to limitations with respect to any one individual, any one participant and any one contract holder: Provided, That "premiums" shall not include any premiums in excess of one million dollars on any unallocated annuity contract not issued under a government retirement plan established under section 401, 403 (b) or 457 of the United States Internal Revenue Code.

(12) "Resident" means any person who resides in this state at the time a member insurer is determined to be an impaired or insolvent insurer and to whom a contractual obligation is owed. A person may be a resident of only one state, which in the case of a person other than a natural person shall be its principal place of business.

(13) "Health insurance" means accident and sickness insurance as defined in subsection (b), section ten, article one of this chapter.
(14) "Supplemental contract" means any agreement entered into for the distribution of policy or contract proceeds.

(15) "Unallocated annuity contract" means any annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under such contract or certificate.

§33-26A-6. Creation of association; required accounts; supervision of commissioner; meetings and records.

(a) There is created a nonprofit legal entity to be known as the West Virginia life and health insurance guaranty association. All member insurers shall be and remain members of the association as a condition of their authority to transact insurance in this state. The association shall perform its functions under the plan of operation established and approved under section ten of this article and shall exercise its powers through a board of directors established under section seven of this article. For purposes of administration and assessment, the association shall maintain the following two accounts:

(1) The life insurance and annuity account which includes the following subaccounts:

(A) Life insurance account;

(B) Annuity account; and

(C) Unallocated annuity account which shall include contracts qualified under section 403 (b) of the United States Internal Revenue Code.

(2) The health insurance account.

(b) The association shall come under the immediate supervision of the commissioner and shall be subject to the applicable provisions of the insurance laws of this state. Meetings or records of the association may be opened to the public upon majority vote of the board of directors of the association.
§33-26A-7. Board of directors; members; vacancies; voting rights; appointment and reimbursement.

(a) The board of directors of the association shall consist of not less than five nor more than nine member insurers serving terms as established in the plan of operation. The members of the board shall be selected by member insurers subject to the approval of the commissioner. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining board members, subject to the approval of the commissioner.

(b) To select the initial board of directors, and initially organize the association, the commissioner shall give notice to all member insurers of the time and place of the organizational meeting. In determining voting rights at the organizational meeting each member insurer shall be entitled to one vote in person or by proxy. If the board of directors is not selected within sixty days after notice of the organizational meeting, the commissioner may appoint the initial members.

(c) In approving selections or in appointing members to the board, the commissioner shall consider, among other things, whether all member insurers are fairly represented.

(d) Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors but members of the board shall not otherwise be compensated by the association for their services.


(a) If a member insurer is an impaired domestic insurer, the association may, in its discretion, and subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer, that are approved by the commissioner, and that are, except in cases of court-ordered conserva-


(1) Guarantee, assume, or reinsure, or cause to be guaranteed, assumed or reinsured, any or all the covered policies or contracts of the impaired insurer;

(2) Provide such moneys, pledges, notes, guarantees or other means as are proper to effectuate subdivision (1) of this subsection and assure payment of the contractual obligations of the impaired insurer pending action under said subdivision (1); or

(3) Loan money to the impaired insurer.

(b)(1) If a member insurer is an impaired insurer, whether domestic, foreign or alien, and the insurer is not paying claims timely, then subject to the preconditions specified in subdivision (2) of this subsection, the association shall, in its discretion, either:

(A) Take any of the actions specified in subsection (a) of this section, subject to the conditions therein; or

(B) Provide substitute benefits in lieu of the contractual obligations of the impaired insurer solely for health claims, periodic annuity benefit payments, death benefits, supplemental benefits, and cash withdrawals for policy or contract owners who petition therefor under claims of emergency or hardship in accordance with standards proposed by the association and approved by the commissioner.

(2) The association shall be subject to the requirements of subdivision (1) of this subsection only if:

(A) The laws of the impaired insurer's state of domicile provide that until all payments of or on account of the impaired insurer's contractual obligations by all guaranty associations, along with all expenses thereof and interest on all payments and expenses, shall have been repaid to the guaranty associations or a plan of repayment by the impaired insurer shall have been approved by the guaranty associations:

   (i) The delinquency proceeding shall not be dismissed;

   (ii) Neither the impaired insurer nor its assets shall be returned to the control of its shareholders or private management;
(iii) It shall not be permitted to solicit or accept new business or have any suspended or revoked license restored; and

(B)(i) If the impaired insurer is a domestic insurer, it has been placed under an order of rehabilitation by a court of competent jurisdiction in this state; or

(ii) The impaired insurer is a foreign or alien insurer;

(I) It has been prohibited from soliciting or accepting new business in this state;

(II) Its certificate of authority has been suspended or revoked in this state; and

(III) A petition for rehabilitation or liquidation has been filed in a court of competent jurisdiction in its state of domicile by the commissioner of the state.

(c) If a member insurer is an insolvent insurer, the association shall, in its discretion, either:

(1) (A) Guarantee, assume or reinsure, or cause to be guaranteed, assumed or reinsured, the policies or contracts of the insolvent insurer; or

(B) Assure payment of the contractual obligations of the insolvent insurer; and

(C) Provide moneys, pledges, guarantees, or other means as are reasonably necessary to discharge such duties; or

(2) With respect only to life and health insurance policies, provide benefits and coverages in accordance with subsection (d) of this section.

(d) When proceeding under (b)(1)(B) or (c)(2) of this section, the association shall, with respect to only life and health insurance policies:

(1) Assure payment of benefits for premiums identical to the premiums and benefits, except for terms of conversion and renewability, that would have been payable under the policies of the insolvent insurer, for claims incurred:

(A) With respect to group policies, not later than the
earlier of the next renewal date under such policies or contracts or forty-five days, but in no event less than thirty days, after the date on which the association becomes obligated with respect to such policies;

(B) With respect to individual policies, not later than the earlier of the next renewal date, if any, under these policies or one year, but in no event less than thirty days, from the date on which the association becomes obligated with respect to such policies;

(2) Make diligent efforts to provide all known insureds or group policyholders with respect to group policies thirty days' notice of the termination of the benefits provided; and

(3) With respect to individual policies, make available to each known insured, or owner if other than the insured, and with respect to an individual formerly insured under a group policy who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of subdivision (4) of this subsection, if the insureds had a right under law or the terminated policy to convert coverage to individual coverage or to continue an individual policy in force until a specified age or for a specified time, during which the insurer had no right unilaterally to make changes in any provision of the policy or had a right only to make changes in premium by class.

(4)(A) In providing the substitute coverage required under subdivision (3) of this subsection, the association may offer either to reissue the terminated coverage or to issue an alternative policy.

(B) Alternative or reissued policies shall be offered without requiring evidence of insurability, and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy.

(C) The association may reinsure any alternative or reissued policy.

(5)(A) Alternative policies adopted by the association shall be subject to the approval of the commissioner. The
association may adopt alternative policies of various types for future issuance without regard to any particular impairment or insolvency.

(B) Alternative policies shall contain at least the minimum statutory provisions required in this state and provide benefits that shall not be unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates which it shall adopt. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but shall not reflect any changes in the health of the insured after the original policy was last underwritten.

(C) Any alternative policy issued by the association shall provide coverage of a type similar to that of the policy issued by the impaired or insolvent insurer, as determined by the association.

(6) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy, the premium shall be set by the association in accordance with the amount of insurance provided and the age and class of risk, subject to approval of the commissioner or by a court of competent jurisdiction.

(7) The association's obligations with respect to coverage under any policy of the impaired or insolvent insurer or under any reissued or alternative policy shall cease on the date that the coverage or policy is replaced by another similar policy by the policyholder, the insured or the association.

(e) When proceeding under subsection (b)(1)(B) or (C) of this section with respect to any policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with subsection (b)(2)(C) of section three of this article.

(f) Nonpayment of premium within thirty-one days after the date required under the terms of any guaranteed, assumed, alternative or reissued policy or contract
or substitute coverage shall terminate the association’s obligations under such policy or coverage under this article with respect to such policy or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of this article.

(g) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the association, and the association shall be liable for unearned premiums due to policy or contract owners arising after the entry of the order.

(h) The protection provided by this article shall not apply where any guaranty protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state.

(i) In carrying out its duties under subsections (b) and (c) of this section, the association may, subject to approval by the court:

(1) Impose permanent policy or contract liens in connection with any guarantee, assumption or reinsurance agreement, if the association finds that the amounts which can be assessed under this article are less than the amounts needed to assure full and prompt performance of the association’s duties under this article, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of such permanent policy or contract liens, to be in the public interest;

(2) Impose temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value.

(j) If the association fails to act within a reasonable period of time as provided in subsections (b)(1)(B), (c) and (d) of this section, the commissioner shall have the powers and duties of the association under this article.
(k) The association may render assistance and advice to the commissioner, upon his request, concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of any impaired or insolvent insurer.

(l) The association shall have standing to appear before any court in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this article. Standing shall extend to all matters germane to the powers and duties of the association, including, but not limited to, proposals for reinsuring, modifying, or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The association shall also have the right to appear or intervene before a court in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over a third party against whom the association may have rights through subrogation of the insurer's policyholders.

(m)(1) Any person receiving benefits under this article shall be deemed to have assigned the rights under, and any causes of action relating to, the covered policy or contract to the association to the extent of the benefits received because of this article, whether the benefits are payments of or on account of contractual obligations, continuation of coverage or provision of substitute or alternative coverages. The association may require an assignment to it of such rights and cause of action by any payee, policy or contract owner, beneficiary, insured or annuitant as a condition precedent to the receipt of any right or benefits conferred by this article upon such person.

(2) The subrogation rights of the association under this subsection shall have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits...
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240 under this article.

241 (3) In addition to subdivisions (1) and (2) above, the association shall have all common law rights of subro-
242 gation and any other equitable or legal remedy which would have been available to the impaired or insolvent insurer or holder of a policy or contract with respect to such policy or contracts.

247 (n) The association may:

248 (1) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this article;

249 (2) Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under section nine of this article and to settle claims or potential claims against it;

255 (3) Borrow money to effect the purpose of this article; any notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic insurers and may be carried as admitted assets;

260 (4) Employ or retain such persons as are necessary to handle the financial transactions of the association, and to perform such other functions as become necessary or proper under this article;

264 (5) Take such legal action as may be necessary to avoid payment of improper claims;

266 (6) Exercise, for the purposes of this article and to the extent approved by the commissioner, the powers of a domestic life or health insurer, but in no case may the association issue insurance policies or annuity contracts other than those issued to perform its obligations under this article.

272 (o) The association may join an organization of one or more other state associations of similar purposes, to further the purposes and administer the powers and duties of the association.

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

(b) There shall be two assessments, as follows:

1. Class A assessments shall be made for the purpose
   of meeting administrative and legal costs and other
   expenses and examinations conducted under the author-
   ity of subsection (e) of section twelve, of this article.
   Class A assessments may be made whether or not
   related to a particular impaired or insolvent insurer.

2. Class B assessments shall be made to the extent
   necessary to carry out the powers and duties of the
   association under section eight with regard to an
   impaired or insolvent insurer.

(c)(1) The amount of any Class A assessment shall be
determined by the board and may be made on a pro rata
or non-pro rata basis. If pro rata, the board may provide
that it be credited against future Class B assessments.
A non-pro rata assessment shall not exceed one hundred
fifty dollars per member insurer in any one calendar
year. The amount of any Class B assessment shall be
allocated for assessment purposes among the accounts
pursuant to an allocation formula which may be based
on the premiums or reserves of the impaired or insolvent
insurer or any other standard deemed by the board in
its sole discretion as being fair and reasonable under the
circumstances.

2. Class B assessments against member insurers for
each account and subaccount shall be in the proportion
that the premiums received on business in this state by
each assessed member insurer on policies or contracts
covered by each account for the three most recent
calendar years for which information is available
preceding the year in which the insurer became
impaired or insolvent, as the case may be, bears to such
(3) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer shall not be made until necessary to implement the purposes of this article. Classification of assessments under subsection (b) of this section and computation of assessments under this subsection shall be made with reasonable degree of accuracy, recognizing that exact determinations may not always be possible.

(d) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated, or deferred, in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section.

(e)(1) The total of all assessments upon a member insurer for the life and annuity account and for each subaccount thereunder shall not in any one calendar year exceed two percent and for the health account shall not in any one calendar year exceed two percent of such insurer's average premiums received in this state on the policies and contracts covered by the account during the three calendar years preceding the year in which the insurer became an impaired or insolvent insurer. If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in either account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon thereafter as permitted by this article.

(2) The board may provide in the plan of operation a method of allocating funds among claims, whether relating to one or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.
(3) If a one percent assessment for any subaccount of
the life and annuity account in any one year does not
provide an amount sufficient to carry out the responsi-
bilities of the association, then pursuant to subdivision
(2), subsection (c) of this section, the board shall assess
all subaccounts of the life and annuity account for the
necessary additional amount, subject to the maximum
stated in subdivision (1), subsection (e) of this section.

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

(g) It shall be proper for any member insurer, in
determining its premium rates and policy owner
dividends as to any kind of insurance within the scope
of this article, to consider the amount reasonably
necessary to meet its assessment obligations under this
article.

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


(a) The association shall submit to the commissioner
a plan of operation and any amendments thereto
necessary or suitable to assure the fair, reasonable and
equitable administration of the association. The plan of operation and any amendments thereto shall become effective upon the commissioner's written approval or unless he has not disapproved of the same within thirty days.

(b) If the association fails to submit a suitable plan of operation within one hundred eighty days following the effective date of this article or if at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this article. Such rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

(c) All member insurers shall comply with the plan of operation.

(d) The plan of operation shall, in addition to requirements enumerated elsewhere in this article:

(1) Establish procedures for handling the assets of the association;

(2) Establish the amount and method of reimbursing members of the board of directors under section seven of this article;

(3) Establish regular places and times for meetings including telephone conference calls of the board of directors;

(4) Establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors;

(5) Establish the procedures whereby selections for the board of directors will be made and submitted to the commissioner;

(6) Establish any additional procedures for assessments under section nine of this article; and

(7) Contain additional provisions necessary or proper
for the execution of the powers and duties of the
association.

(e) The plan of operation may provide that any or all
powers and duties of the association, except those under
subdivision (3), subsection (m), section eight, and section
nine of this article, are delegated to a corporation,
association, or other organization which performs or will
perform functions similar to those of this association, or
its equivalent, in two or more states. Such a corporation,
association or organization shall be reimbursed for any
payments made on behalf of the association and shall be
paid for its performance of any function of the associ-
ation. A delegation under this subsection shall take
effect only with the approval of both the board of
directors and the commissioner, and may be made only
to a corporation, association or organization which
extends protection not substantially less favorable and
effective than that provided by this article.

§33-26A-11. Duties and powers of commissioner of
insurance.

In addition to the duties and powers enumerated
elsewhere in this article:

(a) The commissioner shall:

(1) Upon request of the board of directors, provide the
association with a statement of the premiums in this and
any other appropriate states for each member insurer;

(2) When an impairment is declared and the amount
of the impairment is determined, serve a demand upon
the impaired insurer to make good the impairment
within a reasonable time. Notice to the impaired insurer
shall constitute notice to its shareholders, if any; the
failure of the insurer to promptly comply with the
demand shall not excuse the association from the
performance of its powers and duties under this article;
and

(3) In any liquidation or rehabilitation proceeding
involving a domestic insurer, be appointed as the
liquidator or rehabilitator.
(b) The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a forfeiture on any member insurer which fails to pay an assessment when due. The forfeiture shall not exceed five percent of the unpaid assessment per month, but no forfeiture shall be less than one hundred dollars per month.

(c) Any action of the board of directors or the association may be appealed to the commissioner by any member insurer if such appeal is taken within sixty days of the final action being appealed. If a member company is appealing an assessment, the amount assessed shall be paid to the association and available to meet association obligations during the pendency of an appeal. If the appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member company. Any final action or order of the commissioner shall be subject to judicial review in a court of competent jurisdiction.

(d) The liquidator, rehabilitator or conservator of any impaired insurer may notify all interested persons of the effect of this article.

§33-26A-12. Prevention of insolvencies; duties of commissioner; coordination with board of directors; duties of the board of directors; requested examinations; procedures and reports.

To aid in the detection and prevention of insurer insolvencies or impairments:

(a) It shall be the duty of the commissioner:

(1) To notify the commissioners of all the other states, territories of the United States and the District of Columbia when he takes any of the following actions against a member insurer:

(A) Revocation of license;
(B) Suspension of license; or

(C) Makes any formal order that such company restrict its premium writing, obtain additional contributions to surplus, withdraw from the state, reinsure all or any part of its business, or increase capital, surplus or any other account for the security of policyholders or creditors: Provided, That such notice shall be mailed to all commissioners within thirty days following the action taken or the date on which the action occurs.

(2) To report to the board of directors when he or she has taken any of the actions set forth in subdivision (1) of subsection (a) of this section or has received a report from any other commissioner indicating that any such action has been taken in another state. Such report to the board of directors shall contain all significant details of the action taken or the report received from another commissioner.

(3) To report to the board of directors when he or she has reasonable cause to believe from any examination, whether completed or in process, of any member company that the company may be an impaired or insolvent insurer.

(4) To furnish to the board of directors the national association of insurance commissioners (NAIC) insurance regulatory information system (IRIS) ratios and listings of companies not included in the ratios developed by the national association of insurance commissioners, and the board may use the information contained therein in carrying out its duties and responsibilities under this section. The report and the information contained therein shall be kept confidential by the board of directors until it is made public by the commissioner or other lawful authority.

(b) The commissioner may seek the advice and recommendations of the board of directors concerning any matter affecting his or her duties and responsibilities regarding the financial condition of member insurers and companies seeking admission to transact insurance business in this state.
(c) The board of directors may, upon majority vote, make reports and recommendations to the commissioner upon any matter germane to the solvency, liquidation, rehabilitation or conservation of any member insurer or germane to the solvency of any company seeking to do an insurance business in this state. The reports and recommendations shall not be considered public documents.

(d) It shall be the duty of the board of directors, upon majority vote, to notify the commissioner of any information indicating any member insurer may be an impaired or insolvent insurer.

(e) The board of directors may, upon majority vote, request that the commissioner order an examination of any member insurer which the board in good faith believes may be an impaired or insolvent insurer. Within thirty days of the receipt of a request, the commissioner shall begin an examination. The examination may be conducted as a national association of insurance commissioner's examination or may be conducted by persons that the commissioner designates. The cost of such examination shall be paid by the association and the examination report shall be treated as are other examination reports. In no event shall the examination report be released to the board of directors prior to its release to the public, but this shall not preclude the commissioner from complying with subsection (a) of this section. The commissioner shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the commissioner, but it shall not be open to public inspection prior to the release of the examination report to the public.

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

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


1 The association may recommend a natural person to serve as a special deputy to act for the commissioner and under his or her supervision in the liquidation, rehabilitation or conservation of any member insurer.


1 (a) Nothing in this article shall be construed to reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

5 (b) Records shall be kept of all negotiations and meetings in which the association or its representatives are involved to discuss the activities of the association in carrying out its powers and duties under section eight of this article. Records of such negotiations or meetings shall be made public only upon the termination of a liquidation, rehabilitation or conservation proceeding involving the impaired or insolvent insurer, upon the termination of the impairment or insolvency of the insurer, or upon the order of a court of competent jurisdiction. Nothing in this subsection shall limit the duty of the association to render a report of its activities under section fifteen of this article.

18 (c) For the purpose of carrying out its obligations under this article, the association shall be deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the association is entitled as assignee or subrogee pursuant to subsection (m), section eight of this article. All assets of the impaired or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all
contractual obligations of the impaired or insolvent insurer as required by this article. Assets attributable to covered policies, as used in this subsection, are that proportion of the assets which the reserves that should have been established for the policies bear to the reserves that should have been established for all policies of insurance written by the impaired or insolvent insurer.

(d) (1) Prior to the termination of any liquidation, rehabilitation or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders and policy owners of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of such insolvent insurer. In making such a determination, consideration shall be given to the welfare of the policyholders of the continuing or successor insurer.

(2) No distribution to stockholders, if any, of an impaired or insolvent insurer shall be made until and unless the total amount of valid claims of the association with interest thereon for funds expended in carrying out its powers and duties under section eight of this article with respect to the insurer have been fully recovered by the association.

(e) (1) If an order for liquidation or rehabilitation of an insurer domiciled in this state has been entered, the receiver appointed under such order shall have a right to recover on behalf of the insurer, from any affiliate that controlled it, the amount of distributions other than stock dividends paid by the insurer on its capital stock made at any time during the five years preceding the petition for liquidation or rehabilitation subject to the limitations of this subsection.

(2) Distribution shall not be recoverable if the insurer shows that when paid the distribution was lawful and reasonable, and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.
(3) Any person who, as an affiliate, controlled the insurer at the time the distributions were paid shall be liable up to the amount of distributions he or she received. Any person who, as an affiliate, controlled the insurer at the time the distributions were declared, shall be liable up to the amount of distributions he or she would have received if they had been paid immediately. If two or more persons are liable with respect to the same distributions, they shall be jointly and severally liable.

(4) The maximum amount recoverable under this subsection shall be the amount required in excess of all other available assets of the impaired or insolvent insurer to pay the contractual obligations of the impaired or insolvent insurer.

(5) If any person under subdivision (3) is insolvent, all its affiliates that controlled it at the time the distribution was paid shall be jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

§33-26A-15. Examination of association; annual report.

The association shall be subject to examination and regulation by the commissioner. The board of directors shall submit to the commissioner, not later than the first day of May of each year, a financial report for the preceding calendar year in a form approved by the commissioner and a report of its activities during the preceding calendar year.


The association shall be exempt from payment of all fees and all taxes levied by this state or any of its subdivisions, except taxes levied on real property.


There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer or its agents or employees, the association or its agents or employees, members of the board of directors, or the commissioner or his or her representatives, for
any action or omission by them in the performance of
their powers and duties under this article. Such
immunity shall extend to the participation in any
organization of one or more other state associations of
similar purposes and to any such organization and its
agents or employees.

§33-26A-18. Stay of court proceedings; reopening default
judgments.

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

§33-26A-19. Prohibited advertisement of insurance
guaranty association act in insurance
sales; notice to policyholders.

(a) A person, including any insurer, agent or affiliate
of an insurer shall not make, publish, disseminate,
circulate or place before the public, or cause directly or
indirectly, to be made, published, disseminated, circu-
lated or placed before the public, in any newspaper,
magazine or other publication, or in the form of a notice,
circular, pamphlet, letter or poster, or over any radio
station or television station, or in any other way, any
advertisement, announcement or statement, written or
oral, which uses the existence of the insurance guaranty
association of this state for the purpose of sales,
solicitation or inducement to purchase any form of
insurance covered by the West Virginia life and health
insurance guaranty association act: Provided, That this
section shall not apply to the association or any other
entity which does not sell or solicit insurance.

(b) Within one hundred eighty days of the effective
date of this section, the association shall prepare a
summary document describing the general purposes
and current limitations of the act and complying with subsection (c) of this section. This document should be submitted to the commissioner for approval. Sixty days after receiving such approval, no insurer may deliver a policy or contract described in subdivision (1) of subsection (b) of section three of this article to a policy or contract holder unless the document is delivered to the policy or contract holder prior to or at the time of delivery of the policy or contract except if subsection (d) of this section applies. The document should also be available upon request by a policyholder. The distribution, delivery, or contents or interpretation of this document shall not mean that either the policy or the contract of the holder thereof would be covered in the event of the impairment or insolvency of a member insurer. The description document shall be revised by the association as amendments to the act may require. Failure to receive this document does not give the policyholder, contract holder, certificate holder or insured any greater rights than those stated in this article.

(c) The document prepared under subsection (b) of this section shall contain a clear and conspicuous disclaimer on its face. The commissioner shall promulgate a rule establishing the form and content of the disclaimer. The disclaimer shall:

(1) State the name and address of the association and insurance department;

(2) Prominently warn the policy or contract holder that the association may not cover the policy or, if coverage is available, it will be subject to substantial limitations and exclusions and conditioned on continued residence in the state;

(3) State that the insurer and its agents are prohibited by law from using the existence of the association for the purpose of sales, solicitation or inducement to purchase any form of insurance;

(4) Emphasize that the policy or contract holder should not rely on coverage under the association when selecting an insurer;
(5) Provide other information as directed by the commissioner.

(d) An insurer or agent may not deliver a policy or contract described in subdivision (1) of subsection (b) of section three of this article and excluded under paragraph (A), subdivision (2), subsection (b) of section three of this article from coverage under this article unless the insurer or agent, prior to or at the time of delivery, gives the policy or contract holder a separate written notice which clearly and conspicuously discloses that the policy or contract is not covered by the association. The commissioner shall by rule specify the form and content of the notice, which rules shall be promulgated on or before the second day of August, one thousand nine hundred ninety-three.
The Joint Committee on Enrolled Bills hereby certifies that the foregoing bill is correctly enrolled.

Chairman Senate Committee

Chairman House Committee

Originating in the House.
Takes effect ninety days from passage.

Clerk of the Senate

Clerk of the House of Delegates

President of the Senate

Speaker of the House of Delegates

The within is approved this the 11th day of May, 1993.

Governor
PRESENTED TO THE
GOVERNOR
Date 4/29/93
Time 11:30 a.m.