TITLE XXXVII
INSURANCE

CHAPTER 408-F
LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION OF 2019

Section 408-F:1

408-F:1 Title. – This chapter shall be known and may be cited as the New Hampshire Life and Health Insurance Guaranty Association Act of 2019.

Source. 2019, 314:1, eff. Jan. 1, 2020.

Section 408-F:2

408-F:2 Purpose. –
I. The purpose of this chapter is to protect, subject to certain limitations, the persons specified in RSA 408-F:5, I against failure in the performance of contractual obligations, under life, health and annuity policies, plans, or contracts specified in RSA 408-F:5, II, because of the impairment or insolvency of the member insurer that issued the policies, plans, or contracts.
II. To provide this protection, an association of member 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 chapter.

Source. 2019, 314:1, eff. Jan. 1, 2020.

Section 408-F:3

408-F:3 Construction. – This chapter shall be liberally construed to effect the purpose under RSA 408-F:2 which shall constitute an aid and guide to interpretation.

Source. 2019, 314:1, eff. Jan. 1, 2020.

Section 408-F:4

408-F:4 Definitions. –
In this chapter:
I. "Account" means either of the 2 accounts created under RSA 408-F:6.
II. "Association" means the New Hampshire life and health insurance guaranty association created under RSA 408-F:6.
III. "Commissioner" means the commissioner of insurance.
IV. "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 RSA 408-F:5.
V. "Covered contract" or "covered policy" means any policy or contract within the scope of this chapter under RSA 408-F:5.
VI. "Health benefit plan" means any hospital or medical expense policy or certificate, or health maintenance organization subscriber contract or any other similar health contract. "Health benefit plan" does not include:
(a) Accident only insurance.
(b) Credit insurance.
(c) Dental only insurance.
(d) Vision only insurance.
(e) Medicare supplement insurance.
(f) Benefits for long-term care, home health care, community-based care, or any combination thereof.
(g) Disability income insurance.
(h) Coverage for on-site medical clinics.
(i) Specified disease, hospital confinement indemnity, or limited benefit health insurance if the types of coverage do not

provide coordination of benefits and are provided under separate policies or certificates.
VII. "Impaired insurer" means a member insurer which, on or after January 1, 2020, is not an insolvent insurer; and
(a) Is deemed by the commissioner to be potentially unable to fulfill its contractual obligations; or
(b) Is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.
VIII. "Insolvent insurer" means a member insurer which on or after January 1, 2020, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.
IX. "Member insurer" means any insurer or health maintenance organization licensed or which holds a certificate of authority to transact in this state any kind of insurance or health insurance organization business for which coverage is provided under RSA 408-F:5, and includes any insurer or health maintenance organization whose license or certificate of authority in this state may have been suspended, revoked, not renewed or voluntarily withdrawn, but does not include:
(a) A nonprofit hospital or medical service organization.
(b) A fraternal benefit society.
(c) A mandatory state pooling plan.
(d) A mutual assessment company or any entity that operates on an assessment basis.
(e) An insurance exchange.
(f) An organization that has a certificate or license limited to the issuance of charitable gift annuities under RSA 403-E.
(g) Any entity similar to any of the above.
X. "Moody's Corporate Bond Yield Average" means the Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto.
XI. "Person" means any individual, corporation, partnership, association, or voluntary organization.
XII. "Premiums" means amounts received on covered policies or contracts less premiums, considerations, and deposits returned on such policies or contracts and less dividends and experience credits on such policies or contracts. "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 RSA 408-F:5, II, except that assessable premium shall not be reduced on account of RSA 408-F:5, II(b)(3) relating to interest limitations and RSA 408-F:5, III(b) relating to limitations with respect to any one individual, any one participant and any one policy or contract holder; provided that "premiums" shall not include:
(a) Any premiums in excess of $5,000,000 on any unallocated annuity contract not issued under a governmental retirement plan established under section 401, 403(b) or 457 of the United States Internal Revenue Code; or
(b) With respect to multiple non-group policies of life insurance owned by one owner, whether the policy or contract owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees or other persons, premiums in excess of $5,000,000 with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.
XIII. "Resident" means a person to whom a contractual obligation is owed and who resides in this state at the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer, whichever occurs first. 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. Citizens of the United States that are either: (a) residents of foreign countries or (b) residents of United States possessions, territories or protectorates that do not have an association similar to the association created by this chapter, shall be deemed residents of the state of domicile of the member insurer that issued the policies or contracts.
XIV. "Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.
XV. "Supplemental contract" means any agreement entered into for the distribution of policy or contract proceeds.
XVI. "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 the contract or certificate.

Source. 2019, 314:1, eff. Jan. 1, 2020.

Section 408-F:5

408-F:5 Coverage and Limitations. –
I. This chapter shall provide coverage for the policies and contracts specified in paragraph II:
(a) To persons who, regardless of where they reside (except for nonresident certificate holders under group policies or contracts), are the beneficiaries, assignees, or payees, including health care providers rendering services covered under health insurance policies or certificates of the persons covered under subparagraph (b); and
(b) To persons who are owners of or certificate holders or enrollees under the policies or contracts, (other than unallocated annuity contracts and structured settlement annuities) and in each case who:
(1) Are residents; or

(2) Are not residents, but only under all of the following conditions:
(A) The member insurers that issued the policies or contracts are domiciled in this state;
(B) The states in which the persons reside have associations similar to the association created by this chapter; and
(C) The persons are not eligible for coverage by an association in any other state because the insurer or health maintenance organization was not licensed in the state at the time specified in the state's guaranty association law.
(c) For unallocated annuity contracts specified in paragraph II, subparagraphs (a) and (b) shall not apply, and this chapter shall, except as provided in subparagraphs (e) and (f), provide coverage to:
(1) Persons who are the owners of the unallocated annuity contracts if the contracts are issued to or in connection with a specified benefit plan whose plan sponsor has its principal place of business in this state; and
(2) Persons who are owners of unallocated annuity contracts issued to or in connection with government lotteries if the owners are residents.
(d) For structured settlement annuities specified in paragraph II; subparagraphs (a) and (b) shall not apply, and this chapter shall, except as provided in subparagraphs (e) and (f), provide coverage to a person who is a payee under a structured settlement annuity, or beneficiary of a payee if the payee is deceased, if the payee:
(1) Is a resident, regardless of where the contract owner resides; or
(2) Is not a resident, but only under both of the following conditions:
(A)(i) The contract owner of the structured settlement annuity is a resident; or
(ii) The contract owner of the structured settlement annuity is not a resident, but the insurer that issued the structured settlement annuity is domiciled in this state, and the state in which the contract owner resides has an association similar to the association created by this chapter; and
(B) Neither the payee or beneficiary nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides.
(e) This chapter shall not provide coverage to:
(1) A person who is a payee or beneficiary of a contract owner resident of this state, if the payee or beneficiary is afforded any coverage by the association of another state;
(2) A person covered under subparagraph (c), if any coverage is provided by the association of another state to the person; or
(3) A person who acquires rights to receive payments through a structured settlement factoring transaction as defined in 26 U.S.C. section 5891(c)(3)(A), regardless of whether the transaction occurred before or after such section became effective.
(f) This chapter is intended to provide coverage to a person who is a resident of this state and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this chapter is provided coverage under the laws of any other state, the person shall not be provided coverage under this chapter. In determining the application of the provisions of this paragraph in situations where a person could be covered by the association of more than one state, whether as an owner, payee, enrollee, beneficiary, or assignee, this chapter shall be construed in conjunction with other state laws to result in coverage by only one association.
II. (a) This chapter shall provide coverage to the persons specified in paragraph I for policies and contracts of direct, non-group life insurance, health insurance, including health maintenance organization subscriber contracts and certificates, or annuities, and supplemental contracts to any of these, for certificates under direct group policies and contracts, and for supplemental contracts to any of these, and for unallocated annuity contracts issued by member insurers, except as limited by this chapter. 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 annuities, annuities issued to or in connection with government lotteries and any immediate or deferred annuity contracts.
(b) Except as otherwise provided in subparagraph (c), this chapter shall not provide coverage for:
(1) A portion of a policy or contract not guaranteed by the member insurer, or under which the risk is borne by the policy or contract owner;
(2) Any policy or contract of reinsurance, unless assumption certificates have been issued;
(3) A portion of a policy or contract to the extent that the rate of interest on which it is based, or the interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or change in value:
(A) Averaged over the period of 4 years prior to the date on which the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier, exceeds a rate of interest determined by subtracting 2 percentage points from Moody's Corporate Bond Yield Average averaged for that same 4-year period or for such lesser period if the policy or contract was issued less than 4 years before the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier; and
(B) On and after the date on which the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier, exceeds the rate of interest determined by subtracting 3 percentage points from Moody's Corporate Bond Yield Average as most recently available;
(4) 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:
(A) A multiple-employer welfare arrangement as defined in 29 U.S.C. section 1002(40);
(B) A minimum premium group insurance plan;
(C) A stop-loss group insurance plan; or
(D) An administrative services only contract;
(5) 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;
(6) 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;
(7) Any unallocated annuity contract issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation;
(8) 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;
(9) Any portion of a policy or contract to the extent that the assessments required by RSA 408-F:9 with respect to the policy or contract are preempted by federal or state law;
(10) A portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this subparagraph, the interest or change in value determined by using the procedures defined in the policy or contract shall be credited as if the contractual date of the crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and shall not be subject to forfeiture;
(11) A policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Part C or Part D of subchapter XVIII, chapter 7 of Title 42 of the United States Code, commonly known as Medicare Part C and D, or subchapter XIX, chapter 7 of Title 42 of the United States Code (commonly known as Medicaid), or any regulations issued pursuant thereto; and
(12) Structured settlement annuity benefits to which a payee or beneficiary has transferred his or her rights in a structured settlement factoring transaction as defined in 26 U.S.C. section 5891(c)(3)(A), regardless of whether the transaction occurred before or after such section became effective.
(c) The exclusion from coverage referenced in subparagraph (b)(3) of this section shall not apply to any portion of a policy or contract, including a rider, that provides long-term care or any other health insurance benefits.
III. The benefits for which the association may become liable shall in no event exceed the lesser of:
(a) The contractual obligations for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer; or
(b)(1) With respect to any one life, regardless of the number of policies or contracts:
(A) $300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;
(B) For health insurance benefits:
(i) $100,000 for coverages not defined as disability income insurance or health benefit plans or long-term care insurance, as defined in RSA 415-D, including any net cash surrender and net cash withdrawal values;
(ii) $300,000 for disability income insurance, and $300,000 for long-term care insurance, as defined in RSA 415-D; or
(iii) $500,000 for health benefit plans;
(C) $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values; or
(2) 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, $250,000 in present value annuity benefits, including net cash surrender and net cash withdrawal values; or
(3) With respect to each payee of a structured settlement annuity or beneficiary or beneficiaries of the payee if deceased, $250,000 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal value, if any.
(4) However, in no event shall the association be obligated to cover more than:
(A) An aggregate of $300,000 in benefits with respect to any one life under subparagraphs (b)(1), (2) and (3) except with respect to benefits for health benefit plans under subparagraph (b)(1)(B)(iii), in which case the aggregate liability of the association shall not exceed $500,000 with respect to any one individual; or
(B) With respect to one owner of multiple, non-group policies of life insurance, whether the policy or contract owner is an

individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees, or other persons, more than $5,000,000 in benefits, regardless of the number of policies and contracts held by the owner.
(5) With respect to either one contract owner provided coverage under subparagraph I(c)(2); or one plan sponsor whose plans own directly or in trust one or more unallocated annuity contracts not included in subparagraph (b)(2) of this paragraph, $5,000,000 in benefits, irrespective of the number of contracts with respect to the contract owner or plan sponsor. However, in the case where one or more unallocated annuity contracts are covered contracts under this chapter and are owned by a trust or other entity for the benefit of 2 or more plan sponsors, coverage shall be afforded by the association if the largest interest in the trust or entity owning the contract or contracts is held by a plan sponsor whose principal place of business is in this state and in no event shall the association be obligated to cover more than $5,000,000 in benefits with respect to all these unallocated contracts.
(6) The limitations set forth in this paragraph are limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignments rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations under this chapter may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights.
(7) For purposes of this chapter, benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.
(8) In performing its obligations to provide coverage under RSA 408-F:8, the association shall not be required to guarantee, assume, reinsure, reissue or perform, or cause to be guaranteed, assumed, reinsured, reissued or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

Source. 2019, 314:1, eff. Jan. 1, 2020.

Section 408-F:6

408-F:6 Creation of the Association. –
I. There is created a nonprofit legal entity to be known as the New Hampshire life and health insurance guaranty association, which shall be the same association created under RSA 404-D:6. All member insurers shall be and remain members of the association as a condition of their authority to transact insurance or a health maintenance organization business in this state. The association shall perform its functions under the plan of operation established and approved under RSA 408-F:10 and shall exercise its powers through a board of directors established under RSA 408-F:7. For purposes of administration and assessment, the association shall maintain 2 accounts:
(a) The life insurance and annuity account which includes the following subaccounts:
(1) Life insurance account;
(2) Annuity account, which shall include annuity contracts owned by a governmental retirement plan (or its trustee) established under section 401, 403(b) or 457 of the United States Internal Revenue Code, but shall otherwise excluded unallocated annuities; and
(3) Unallocated annuity account which shall exclude contracts owned by a governmental retirement benefit plan, or its trustee established under section 401, 403(b), or 457 of the United States Internal Revenue Code.
(b) The health account.
II. 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.

Source. 2019, 314:1, eff. Jan. 1, 2020.

Section 408-F:7

408-F:7 Board of Directors. –
I. The board of directors of the association shall consist of not less than 7 nor more than 11 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.
II. In approving selections or in appointing members to the board, the commissioner shall consider, among other things, whether all member insurers are fairly represented.
III. Members of the board may be reimbursed from the assets of the association for expense 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.

Source. 2019, 314:1, eff. Jan. 1, 2020.

Section 408-F:8

408-F:8 Powers and Duties of the Association. –

I. 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 conservation or rehabilitation, also approved by the impaired insurer:

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

(b) Provide such moneys, pledges, notes, guarantees, or other means as are proper to effectuate subparagraph (a) and assure payment of the contractual obligations of the impaired insurer pending action under subparagraph (a); and

(c) Loan money to the impaired insurer.

II. (a) If a member insurer is an impaired insurer and the insurer is not paying claims timely, then subject to the preconditions specified in subparagraph (b), the association shall, in its discretion, either:

(1) Take any of the actions specified in paragraph I, subject to the conditions in such paragraph; or

(2) 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.

(b) The association shall be subject to the requirements of subparagraph (a) only if:

(1) The laws of its 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 such 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:

(A) The delinquency proceeding shall not be dismissed;

(B) Neither the impaired insurer nor its assets shall be returned to the control of its shareholders or private management;

(C) It shall not be permitted to solicit or accept new business or have any suspended or revoked license restored; and

(2)(A) The impaired insurer is a domestic insurer, and it has been placed under an order of rehabilitation by a court of competent jurisdiction in this state; or

(B) The impaired insurer is a foreign insurer; and

(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.

III. If a member insurer is an insolvent insurer, the association shall, in its discretion, either:

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

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

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

(b) With respect only to policies and contracts, provide benefits and coverages in accordance with paragraph IV.

IV. When proceeding under paragraph II(a)(2) or III(b), the association shall, with respect to policies and contracts:

(a) Assure payment of benefits that would have been payable under the policies or contracts of the insolvent insurer, for claims incurred:

(1) With respect to group policies and contracts, not later than the earlier of the next renewal date under such policies or contracts or 45 days, but in no event less than 30 days, after the date on which the association becomes obligated with respect to the policies and contracts.

(2) With respect to individual policies, contracts and annuities, not later than the earlier of the next renewal date (if any) under the policies or contracts or one year, but in no event less than 30 days, from the date on which the association becomes obligated with respect to the policies or contracts.

(b) Make diligent efforts to provide all known insureds, enrollees or annuitants or group policyholders or contract owners with respect to group policies and contracts 30 days notice of the termination of the benefits provided.

(c) With respect to individual policies and contracts covered by the association, make available to each known insured, enrollee, or annuitant or owner if other than the insured, and with respect to an individual formerly an insured, enrollee, or annuitant under a group policy or contract who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of subparagraph (d), if the insureds, enrollees, or annuitants had a right under law or the terminated policy, contract or annuity to convert coverage to individual coverage or

to continue an individual policy, contract, or annuity in force until a specified age or for a specified time, during which the insurer or health maintenance organization had no right unilaterally to make changes in any provision of the policy, contract, or annuity or had a right only to make changes in premium by class.
(d)(1) In providing the substitute coverage required under subparagraph (c), the association may offer either to reissue the terminated coverage or to issue an alternative policy or contract at actuarially justified rates, subject to the approval of the commissioner.
(2) Alternative or reissued policies or contracts shall be offered without requiring evidence of insurability, and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy or contract.
(3) The association may reinsure any alternative or reissued policy or contract.
(e)(1) Alternative policies or contracts adopted by the association shall be subject to the approval of the commissioner. The association may adopt alternative policies or contracts of various types for future issuance without regard to any particular impairment or insolvency.
(2) Alternative policies or contracts 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 or contract was last underwritten.
(3) Any alternative policy or contract issued by the association shall provide coverage of a type similar to that of the policy or contract issued by the impaired or insolvent insurer, as determined by the association.
(f) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy or contract, the premium shall be actuarially justified and set by the association in accordance with the amount of insurance or coverage provided and the age and class of risk, subject to prior approval of the commissioner.
(g) The association's obligations with respect to coverage under any policy or contract of the impaired or insolvent insurer or under any reissued or alternative policy or contract shall cease on the date such coverage or policy or contract is replaced by another similar policy or contract by the policy or contract owner, the insured, the enrollee, or the association.
V. When proceeding under paragraphs II(a)(2) or III 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 RSA 408-F:5, II(b)(3).
VI. Nonpayment of premiums within 31 days after the date required under the terms of any guaranteed, assumed, alternative or reissued policy or contract or substitute coverage shall terminate the association's obligations under the policy or contract, or coverage under this chapter with respect to the policy, contract, 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 chapter.
VII. 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.
VIII. The protection provided by this chapter 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.
IX. In carrying out its duties under paragraphs II and III, the association may, subject to approval by the court:
(a) 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 chapter are less than the amounts needed to assure full and prompt performance of the association's duties under this chapter, 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.
(b) 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.
X. If the association fails to act within a reasonable period of time as provided in paragraphs II(a)(2), III, and IV, the commissioner shall have the powers and duties of the association under this chapter with respect to impaired or insolvent insurers.
XI. The association may render assistance and advice to the commissioner, upon the commissioner's request, concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of any impaired or insolvent insurer.
XII. 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 chapter. Such standing shall extend to all matters germane to the powers and duties of the association, including, but not limited to, proposals for reinsuring, reissuing, modifying, or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The association shall also have the right to appear or intervene before a court 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.
XIII. (a) Any person receiving benefits under this chapter 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 chapter, whether the benefits are payments of or on account of contractual obligations, continuation of coverage, or provision of substitute or alternative policies, contracts, or coverages. The association may require an assignment to it of such rights and cause of action by any enrollee, payee, policy or contract owner, beneficiary, insured or annuitant, as a condition precedent to the receipt of any right or benefits conferred by this chapter upon such person.
(b) The subrogation rights of the association under this paragraph shall have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this chapter.
(c) In addition to subparagraphs (a) and (b), the association shall have all common law rights of subrogation and any other equitable or legal remedy which would have been available to the impaired or insolvent insurer or owner, beneficiary, enrollee, or payee of a policy or contract with respect to such policy or contracts.
XIV. The association may:
(a) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this chapter.
(b) Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under RSA 408-F:9 and to settle claims or potential claims against it.
(c) Borrow money to effect the purposes of this chapter; any notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic member insurers and may be carried as admitted assets.
(d) 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 chapter.
(e) Take such legal action as may be necessary to avoid payment of improper claims.
(f) Exercise, for the purposes of this chapter and to the extent approved by the commissioner, the powers of a domestic life insurer, health insurer, or health maintenance organization, but in no case may the association issue policies or contracts other than those issued to perform its obligations under this chapter.
(g) Unless prohibited by law, in accordance with the terms and conditions of the policy or contract, file for actuarially justified rate or premium increases for any policy or contract for which it provided coverage under this chapter.
XV. 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.
XVI. In carrying out its duties in connection with guaranteeing, assuming, reissuing or reinsuring policies or contracts under paragraph I or II, the association may issue substitute coverage for a policy or contract that provides an interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with the following provisions:
(a) In lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contracts provides for:
(1) A fixed interest rate; or
(2) Payment of dividends with minimum guarantees; or
(3) A different method for calculating interest or changes in value;
(b) There is no requirement for evidence of insurability, waiting period or other exclusion that would not have applied under the replaced policy or contract; and
(c) The alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms.

Source. 2019, 314:1, eff. Jan. 1, 2020.

Section 408-F:9

408-F:9 Assessments. –
I. 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 30 days after prior written notice to the member insurers.
II. There shall be 2 assessments, as follows:
(a) Class A assessments shall be made for the purpose of meeting administrative and legal costs and other expenses and examinations conducted under the authority of RSA 408-F:12, V. Class A assessments may be made whether or not related to a particular impaired or insolvent insurer.
(b) Class B assessments shall be made to the extent necessary to carry out the powers and duties of the association under RSA 408-F:8 with regard to an impaired or an insolvent insurer.
III. (a) 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.

(b) The amount of any Class B assessment, except for assessments related to long-term care insurance, shall be allocated for assessment purposes between the accounts and among the subaccounts of the life insurance and annuity account 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.
(c) The amount of the Class B assessment for long-term care insurance written by the impaired or insolvent insurer shall be allocated according to a methodology included in the plan of operation and approved by the commissioner. The methodology shall provide for 50 percent of the assessment to be allocated to accident and health member insurers and 50 percent to be allocated to life and annuity member insurers.
(d) 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 or policies or contracts covered by each account for the 3 most recent calendar years for which information is available preceding the year in which the member insurer became impaired or insolvent, as the case may be, bears to such premiums received on business in this state for such calendar years by all assessed member insurers.
(e) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer shall not be made until necessary to implement the purposes of this chapter. Classification of assessments under paragraph II and computation of assessments under this paragraph shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible.
IV. The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section.
V. (a) Subject to the provisions of subparagraph (b), the total of all assessments authorized by the association with respect to a member insurer for each subaccount of the life insurance and annuity account and for the health account shall not in any one calendar year exceed 2 percent of that member insurer's average annual premiums received in this state on the policies and contracts covered by the subaccount or account during the 3 calendar years preceding the year in which the member 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 chapter.
(b) 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.
(c) 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 responsibilities of the association, then pursuant to subparagraph III(b), the board shall access all subaccounts of the life and annuity account for the necessary additional amount, subject to the maximum stated in subparagraph V(a).
VI. The board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each member 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.
VII. It shall be proper for any member insurer, in determining its premium rates and policy owner dividends as to any kind of insurance or health maintenance organization business within the scope of this chapter, to consider the amount reasonably necessary to meet its assessment obligations under this chapter.
VIII. The association shall issue to each member insurer paying an assessment under this chapter, 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 member 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.

Source. 2019, 314:1, eff. Jan. 1, 2020.

Section 408-F:10

408-F:10 Plan of Operation. –
I. (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 the commissioner has not disapproved it within 30 days.
(b) If the association fails to submit a suitable plan of operation within 120 days after January 1, 2020, or if at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt such reasonable rules under RSA 541-A as are necessary or advisable to effectuate the provisions of this chapter. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.
II. All member insurers shall comply with the plan of operation.
III. The plan of operation shall, in addition to requirements enumerated elsewhere in this chapter:
(a) Establish procedures for handling the assets of the association.
(b) Establish the amount and method of reimbursing members of the board of directors under RSA 408-F:7.
(c) Establish regular places and times for meetings including telephone conference calls of the board of directors.
(d) Establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors.
(e) Establish the procedures whereby selections for the board of directors will be made and submitted to the commissioner.
(f) Establish any additional procedure for assessments under RSA 408-F:9.
(g) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.
IV. The plan of operation may provide that any or all powers and duties of the association, except those under RSA 408-F:8, XIII(c) and RSA 408-F:9, 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 2 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 association. A delegation under this paragraph 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 chapter.

Source. 2019, 314:1, eff. Jan. 1, 2020.

Section 408-F:11

408-F:11 Duties and Powers of the Commissioner. –
In addition to the duties and powers enumerated elsewhere in this chapter:
I. The commissioner shall:
(a) 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.
(b) 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 impaired insurer to promptly comply with such demand shall not excuse the association from the performance of its powers and duties under this chapter.
(c) In any liquidation or rehabilitation proceeding involving a domestic insurer, be appointed as the liquidator or rehabilitator.
II. The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact business in this state of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a forfeiture on any member insurer which fails to pay an assessment when due. Such forfeiture shall not exceed 5 percent of the unpaid assessment per month, but no forfeiture shall be less than $100 per month.
III. Any action of the board of directors or the association may be appealed to the commissioner by any member insurer if the appeal is taken within 60 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.
IV. The liquidator, rehabilitator, or conservator of any impaired insurer may notify all interested persons of the effect of this chapter.

Source. 2019, 314:1, eff. Jan. 1, 2020.

Section 408-F:12

408-F:12 Prevention of Insolvencies. –
To aid in the detection and prevention of member insurer insolvencies or impairments:
I. It shall be the duty of the commissioner:
(a) To notify the commissioners of all the other states, territories of the United States, and the District of Columbia when the commissioner takes any of the following actions against a member insurer:
(1) Revocation of license;
(2) Suspension of license; or
(3) Makes any formal order that such member insurer 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 policy owners, contract owners, certificate holders, or creditors. The notice shall be mailed to all commissioners within 30 days following the action taken or the date on which such action occurs.
(b) To report to the board of directors when the commissioner has taken any of the actions set forth in subparagraph (a) or has received a report from any other commissioner indicating that any such action has been taken in another state. The report to the board of directors shall contain all significant details of the action taken or the report received from another commissioner.
(c) To report to the board of directors when the commissioner 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.
(d) To furnish to the board of directors the 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 such time as made public by the commissioner or other lawful authority.
II. The commissioner may seek the advice and recommendations of the board of directors concerning any matter affecting the duties and responsibilities of the commissioner regarding the financial condition of member insurers and insurers and health maintenance organizations seeking admission to transact business in this state.
III. 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 insurer or health maintenance organization seeking to do business in this state. Such reports and recommendations shall not be considered public documents.
IV. 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.
V. 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 30 days of the receipt of such request, the commissioner shall begin an examination. The examination may be conducted as a National Association of Insurance Commissioners examination or may be conducted by such persons as the commissioner designates. The cost of the examination shall be paid by the association and the examination report shall be treated as are other examination reports. 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 paragraph I. 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.
VI. The board of directors may, upon majority vote, make recommendations to the commissioner for the detection and prevention of member insurer insolvencies.
VII. 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 the insolvency. The board shall cooperate with the boards of directors of guaranty associations in other states in preparing a report on the history and causes of insolvency of a particular insurer, and may adopt by reference any report prepared by such other associations.

Source. 2019, 314:1, eff. Jan. 1, 2020.

Section 408-F:13

408-F:13 Credits for Assessments Paid. –
I. A member insurer may offset against its tax liability under RSA 400-A any assessment described in RSA 408-F:9, II(b) for the life insurance and annuity account, and for the health account for guaranteeing the performance of contractual obligations of an impaired or insolvent insurer in regard to disability income coverages only, to the extent of 20 percent of the amount of the assessment for each of the 5 calendar years following the year in which the assessment was paid. If a member insurer ceases doing business, all uncredited assessments described above may be credited against its tax liability

under RSA 400-A for the year it ceases doing business.
II. Any sums acquired by refund from the association by member insurers, as stated in RSA 408-F:9, VI, and which were previously offset against taxes as described in paragraph I, shall be paid by these member insurers to the state of New Hampshire in the manner required by the commissioner. The association shall notify the commissioner that refunds have been made.

Source. 2019, 314:1, eff. Jan. 1, 2020.

Section 408-F:14

408-F:14 Miscellaneous Provisions. –
I. Nothing in this chapter 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.
II. 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 RSA 408-F:8. Records of the 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 paragraph shall limit the duty of the association or render a report of its activities under this section.
III. For the purpose of carrying out its obligations under this chapter, 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 subrogee, pursuant to RSA 408-F:8, XIII. 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 chapter. Assets attributable to covered policies or contracts, as used in this subsection, are that proportion of the assets which the reserves that should have been established for such policies or contracts bear to the reserves that should have been established for all policies of insurance or health benefit plans written by the impaired or insolvent insurer.
IV. (a) 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, contract owners, certificate holders, enrollees and policy owners of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of the insolvent insurer. In such a determination, consideration shall be given to the welfare of the policy owners, contract owners, certificate holders, and enrollees of the continuing or successor member insurer.
(b) 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 RSA 408-F:8 with respect to the member insurer have been fully recovered by the association.
V. (a) If an order for liquidation or rehabilitation of a member insurer domiciled in this state has been entered, the receiver appointed under the order shall have a right to recover on behalf of the member insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the member insurer on its capital stock, made at any time during the 5 years preceding the petition for liquidation or rehabilitation subject to the limitations of subparagraphs (b)-(d).
(b) No such distribution shall be recoverable if the member insurer shows that when paid the distribution was lawful and reasonable, and that the member insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the member insurer to fulfill its contractual obligations.
(c) Any person who was an affiliate that controlled the member insurer at the time the distributions were paid shall be liable up to the amount of distributions received. Any person who was an affiliate that controlled the member insurer at the time the distributions were declared, shall be liable up to the amount of distributions which would have been received if they had been paid immediately. If 2 or more persons are liable with respect to the same distributions, they shall be jointly and severally liable.
(d) The maximum amount recoverable under this paragraph shall be the amount needed in excess of all other available assets of the insolvent insurer to pay the contractual obligations of the insolvent insurer.
(e) If any person liable under subparagraph (c) 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.

Source. 2019, 314:1, eff. Jan. 1, 2020.

Section 408-F:15

408-F:15 Examination of the Association; Annual Report. – The association shall be subject to examination and regulation by the commissioner. The board of directors shall submit to the commissioner each year, not later than 120 days after the association's fiscal year, a financial report in a form approved by the commissioner and a report of its activities during the preceding fiscal year.

Source. 2019, 314:1, eff. Jan. 1, 2020.

Section 408-F:16

408-F:16 Tax Exemptions. – 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.

Source. 2019, 314:1, eff. Jan. 1, 2020.

Section 408-F:17

408-F:17 Immunity. – 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 the commissioner's representatives, for any action or omission by them in the performance of their powers and duties under this chapter. 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.

Source. 2019, 314:1, eff. Jan. 1, 2020.

Section 408-F:18

408-F:18 Stay of Proceedings; Reopening Default Judgments. – All proceedings in which the insolvent insurer is a party in any court in this state shall be stayed 60 days from the date an order of liquidation, rehabilitation or conservation is final to permit proper legal action by the association on any matters germane to its powers or duties. As to judgment under any decision, order, verdict, or finding based on default, the association may apply to have such judgment set aside by the same court that made such judgment and shall be permitted to defend against such suit on the merits.

Source. 2019, 314:1, eff. Jan. 1, 2020.

Section 408-F:19

408-F:19 Prohibited Advertisement of Insurance Guaranty Association Act in Insurance Sales; Notice to Policyholders. –

I. No person, including a member insurer, agent or affiliate of a member insurer shall make, publish, disseminate, circulate, or place before the public, or cause directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in any newspaper, magazine or other publication, 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, or other coverage covered by the New Hampshire life and health insurance guaranty association act. Provided, however, that this paragraph shall not apply to the New Hampshire life and health insurance guaranty association or any other entity which does not sell or solicit insurance or coverage by a health maintenance organization. The use of the protection afforded by this chapter, other than as provided by this paragraph, by any person in the sale, marketing, or advertising of insurance constitutes unfair competition and unfair practices under the New Hampshire unfair trade practices act, and is subject to sanctions imposed in that chapter.

II. Within 180 days after January 1, 2020, the association shall prepare a summary document describing the general purposes and current limitations of the chapter and complying with paragraph III. This document shall be submitted to the commissioner for approval. Unless paragraph IV applies, at the expiration of the 60th day after the date on which the commissioner approves the document, a member insurer may not deliver a policy or contract covered by a guaranty fund to a policy owner, contract owner, certificate holder, or enrollee unless the summary document is delivered to the policy owner, contract owner, certificate holder, or enrollee prior to or at the time of delivery of the policy or contract. The document shall also be available upon request by a policy owner, contract owner, certificate holder, or enrollee. The distribution, delivery or contents or interpretation of this document does not guarantee that either the policy or the contract or the policy owner,

contract owner, certificate holder, or enrollee is 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 chapter may require. Failure to receive this document does not give the policy owner, contract owner, certificate holder, enrollee, or insured any greater rights than those stated in this chapter.

III. The document prepared under paragraph II shall contain a clear and conspicuous disclaimer on its face. The commissioner shall approve the disclaimer. The disclaimer shall:

(a) State the name, address, and telephone number of the life and health insurance guaranty association and insurance department.

(b) Prominently warn the policy owner, contract owner, certificate holder, or enrollee that the life and health insurance guaranty association may not cover the policy or contract or, if coverage is available, it will be subject to substantial limitations and exclusions and conditioned on continued residence in the state.

(c) State the types of policies or contracts for which guaranty funds will provide coverage.

(d) State that the member insurer and its agents are prohibited by law from using the existence of the life and health insurance guaranty association for the purpose of sales, solicitation, or inducement to purchase any form of insurance or health maintenance organization coverage.

(e) State that the policy owner, contract owner, certificate holder, or enrollee should not rely on coverage under the life and health insurance guaranty association when selecting an insurer or health maintenance organization.

(f) Explain rights available and procedures for filing a complaint to allege a violation of any provisions of this chapter.

(g) Provide other information as directed by the commissioner, including but not limited to, sources for information about the financial condition of insurers provided that the information is not proprietary and is subject to disclosure under that state's public records law.

IV. No insurer or agent may deliver a policy or contract not covered by the association unless the insurer or agent, prior to or at the time of delivery, gives the policy owner, contract owner, certificate holder, or enrollee a separate written notice which clearly and conspicuously discloses that the policy or contract is not covered by the life and health insurance guaranty association. The commissioner shall approve the notice.

Source. 2019, 314:1, eff. Jan. 1, 2020.

Section 408-F:20

408-F:20 Prospective Application. – This chapter shall not apply to any member insurer which is insolvent or unable to fulfill its contractual obligations on December 31, 2019.

Source. 2019, 314:1, eff. Jan. 1, 2020.