Preface

While a great deal of care has been taken to provide accurate and current information, the ideas, suggestions, general principles and conclusions presented in this text are subject to local, state and federal laws and regulations, court cases and any revisions of the same. The student is thus urged to consult legal counsel regarding any points of law. This text should not be used as a substitute for competent legal advice.

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WELCOME TO INSURANCE SCHOOLS

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ABOUT OUR COURSE

The course you are about to take has been designed to help you successfully meet the challenges of the state license examination. Our objective is to prepare you to successfully pass the state examination on your first attempt. However, we cannot meet this objective without your help! Here is what we need you to do to be successful in your first attempt:

1. Find a quiet place to read and study with no interruptions.

2. If you do not understand a term or phrase, look it up and write it down. This procedure will help reinforce your understanding of the term or phrase in question.

3. Thoroughly read and review each section and take the quiz at the end of the section. After grading your quiz, look up the correct answer for any questions you answered incorrectly.

4. Think! Think! Think! When you begin the state examination, think about what the question is asking you. You have been exposed to the subject; however, the test writer is phrasing the question in a way to make you think.

TIPS ON TAKING OBJECTIVE TESTS

Taking objective tests is a skill, just as playing golf or swimming or playing a musical instrument. If you remember learning one of those skills, you'll recognize that learning to take a test requires practice. Unfortunately, many of those preparing for a state licensing exam have not taken a professional test for a long time. For this reason, taking practice exams is an important part of this license training course.

Here are a few basic ideas to remember while taking the practice exams that accompany this course and most importantly, the state exam. The practice exams are not a substitute for understanding the course material, but following these simple rules will help you avoid making careless mistakes.

1. SLOW DOWN! Even if you pride yourself on being a quick reader, remember that you're trying to pass an examination, not to win a speed reading contest. You will have plenty of time to complete the exam, and there are no bonus points for finishing in a hurry.

2. READ CAREFULLY! Don't select the first response that looks correct -- read all of them! There may be another answer that is more nearly correct, or the question may call for more than one correct answer.

3. LOOK OUT FOR NEGATIVE QUESTIONS! Keep a sharp eye open for the words "not" "except" "unless" or "until." They are usually printed in bold type, and they mean that you have to look for a response that is not correct.

4. DON'T TRY TO READ TOO MUCH INTO THE QUESTION! The person who wrote the question is not trying to be subtle; they don't expect expert knowledge of fine details. Pick out the one best answer and move on.

5. DON'T SPEND TOO MUCH TIME ON ANY ONE QUESTION! If you are unable to decide on a response, there are two options open to you:

   (a) Skip the question for the moment and come back to it after you have finished the examination. You may find another question that provides the clue you are looking for.

   (b) Eliminate the responses you know are wrong, and then make your best guess. Don't leave any blank responses. There is no penalty for a wrong answer, and you might get lucky.

6. USE THE "TRUE-FALSE" TECHNIQUE. Treat each multiple-choice question as if it were four "true-false" questions. Take each response in turn and ask yourself, "Is this response true or false?" This will be especially helpful when you are looking for the proper response on a "negative" question.

7. FINALLY: FIRST THOUGHTS ARE BEST!

GOOD LUCK!!

West Virginia Laws

This text is based on the provisions found in **Chapter 33** of West Virginia Laws pertaining to the Property and Casualty insurance producer's license exam and the provisions found in **Chapter 23** – West Virginia Workers Compensation Laws:

Chapter 33:

Article	Title
1	Definitions
2	Insurance Commissioner
3	Licensing, Fees and Taxation of Insurers
6	The Insurance Policy
6A	Cancellation and Nonrenewal of Automobile Liability Policies
6B	Declination of Automobile Liability Insurance
11	Unfair Trade Practices
12	Insurance Producers and Solicitors
12C	Surplus Lines
17	Fire and Marine Insurance
17A	Property Insurance Declination, Termination and Disclosure
20	Rates and Rating Organizations
20A	West Virginia Essential Insurance Coverage Act
20C	Cancellation or Nonrenewal of Malpractice Insurance Policies
26	West Virginia Guaranty Association Act
30	Mine Subsidence Insurance
44	Unauthorized Insurers Act

Chapter 23:

1	Employers and Employees subject to Workers Compensation

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West Virginia Property & Casualty Insurance Laws and Regulations

The West Virginia Insurance Department and Insurance Commissioner

Broad Powers

The Insurance Commissioner is the chief executive officer of the Insurance Department. He or she is appointed to this position by the governor with the advice and consent of the legislature for a six year term. However, the Insurance Commissioner serves at the will and direction of the governor. During his/her term, the Commissioner must sever all ties with any insurance company except as a claimant or policyholder. (33-2-1)

The office of the Insurance Commissioner is granted the power and responsibility to:

- Enforce Chapter 33 of the Insurance Code
- Affix his/her official seal to all documents and papers when the official seal is required.
- On or before the 10th day of each month, pay into the state treasury all fees and moneys received.
- Conduct hearings of insurance matters to determine if any person has violated state law.
- Employ legal counsel or call upon attorney general for legal assistance and representation. (33-2-3)
- While conducting a hearing, has the authority and power to administer oaths, take depositions, subpoena witnesses and compel their attendance.
- While conducting a hearing, has the authority and power to administer oaths, examine any person under oath, and compel any person to testify in the matter.
- While conducting a hearing, has the authority and power to require the production of any books, papers, records, correspondence or other documents that he feels are relevant to the inquiry.
- Report to the governor and legislature on Department operations annually or as requested or required by law. (33-2-4)

Examination of Records

The purpose of this section is to provide an effective and efficient system for examining the activities, operations, financial condition and affairs of all persons transacting the business of insurance in this state. The provisions of this section are intended to enable the Commissioner

to adopt a flexible system of examinations which directs resources as may be considered appropriate and necessary for the administration of the insurance and insurance-related laws of this state.

The Insurance Department may examine the affairs, transactions, accounts, records, documents and assets of each authorized insurer or licensed producer ***as often as he or she deems necessary***.

The Commissioner or his/her accredited examiners must examine ***each domestic insurer at least once every five years***, and as often as deemed necessary. The Commissioner also examines each insurer applying for a license to transact business in West Virginia. Each domestic insurer's financial condition and method of doing business is checked to ensure it has complied with all the laws and regulations of this state. The Commissioner must also examine any ***foreign or alien insurer*** licensed to transact insurance in this state ***at least once every five years***. The examination may be limited to its United States business. The Commissioner may accept an examination report prepared by the insurance department for the insurer's state of domicile if made according to the accredited standards of the National Association of Insurance Commissioners.

Personnel of the Insurance Department conducting an examination of an insurer are compensated for each day worked at a rate set by the Commissioner. Personnel are also reimbursed for travel and living expenses.

When conducting an examination, the Commissioner may hire attorneys, appraisers, independent actuaries, independent certified public accountants or other professionals and specialists as examiners. The cost of the examination must be ***paid by the insurance company being examined***. Examiners have the power to issue subpoenas, to administer oaths and to examine under oath any person on a matter relevant to the examination, analysis or review. During the examination of any company, the Commissioner may examine or investigate any person or the business of any person relevant to the examination of the company.

The Commissioner may require any examiner to furnish a bond in such amount as Commissioner may determine to be appropriate and the bond must be approved, filed and premium paid, with suitable proof submitted to the Commissioner, prior to commencement of employment by the Commissioner. No examiner may be appointed by the Commissioner if the examiner, either directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in any person subject to examination.

The Commissioner may also examine the books, records, papers, documents, correspondence and methods of doing business of any insurance producer, broker, surplus lines broker or solicitor licensed in West Virginia. Examiners are granted free access to all these materials, as needed. The license of any insurance producer, broker, surplus lines broker or solicitor who refuses to submit to the examination will be revoked.

Any company (by its officers, directors, employees or producers) refusing to submit to examination or to comply with any reasonable written request of the examiners will face

suspension, revocation, refusal or nonrenewal of any license or authority held by the company to engage in insurance business. Additionally, the Commissioner and any examiners are granted special immunity from liability while performing their duties in good faith during an examination.

All insurers subject to examination must pay an annual examination assessment fee to the Commissioner by the first of July. The Commissioner's Examination Revolving Fund uses the assessments to cover the costs of the examinations.

Examination reports on insurers must comply with the following requirements:

- All examination reports must be comprised of only facts appearing upon the books, records or other documents of the company, its agents or other persons examined or as ascertained from the testimony of its officers or agents or other persons examined concerning its affairs and any conclusions and recommendations the examiners find reasonably warranted from the facts;
- No later than 60 days following completion of the examination the examiner in charge must file with the Commissioner a verified written report of examination under oath. Upon receipt of the verified report, the Commissioner will transmit the report to the company examined, together with a notice which will afford the company examined a reasonable opportunity of not more than 30 days to make a written submission or rebuttal with respect to any matters contained in the examination report;
- Within 30 days of the end of the period allowed for the receipt of written submissions or rebuttals the Commissioner will fully consider and review the report, together with any written submissions or rebuttals and any relevant portions of the examiner's work papers and enter an order:

    - Adopting the examination report as filed or with modification or corrections. If the examination report reveals that the company is operating in violation of any law, rule or prior order of the Commissioner, the Commissioner may order the company to take any action the Commissioner considers necessary and appropriate to cure the violation; or
    - Rejecting the examination report with directions to the examiners to reopen the examination for purposes of obtaining additional data, documentation or information and refiling of the report; or
    - Calling for an investigatory hearing with no less than 20 days' notice to the company for purposes of obtaining additional documentation, data, information and testimony.

All orders entered as a result of the examination report must be accompanied by findings and conclusions resulting from the Commissioner's consideration and review of the report, relevant examiner work papers and any written submissions or rebuttals. Any order will be considered a final administrative decision and may be appealed as provided by law and will be served upon the company by certified mail, together with a copy of the adopted examination report. Within 30 days of the issuance of the adopted report the company must file affidavits executed by each of its directors stating under oath that they have received a copy of the adopted report and related orders. (33-2-9)

Notice and Conduct of Hearings

Whenever the Commissioner is required to give notice of a hearing to any person the service of such notice will be deemed proper and effective when such notice is made by United States mail, postage prepaid, addressed to the principal place of business or residence of such person as last recorded in the Commissioner's office, or by standard service of process, if the individual is a licensee or an employee of a licensee. If the individual is neither a licensee nor an employee of a licensee, notice may be by standard service of process only. (33-2-12)

The Insurance Commissioner may call and hold a hearing for any purpose he or she deems necessary as follows:

- If an individual requests a hearing, it must be held within ***45 days*** of receipt of the request unless postponed by mutual agreement.
- The Insurance Commissioner will give at least ***15 days*** notice, through the US mail, of the time, place and matter to be considered to all those directly involved.
- Within ***45 days*** after the completion of hearing, the Insurance Commissioner will render a decision.
- At the discretion of the Insurance Commissioner, a re-hearing may be granted upon written request filed with the Commissioner within ***30 days*** of the decision.
- The Commissioner will allow persons affected by these hearings to appear in person or with counsel (an attorney).

The Commissioner may assign the costs of any hearing or rehearing for the attendance of witnesses, service of subpoenas, records and transcripts to any party against whom findings were made as a result of the hearing. (33-2-13)

(Note: An easy way to remember these "time frames" is ***45/15/45/30***. The state examination may include questions about this process.)

Penalties

Enforcement of Orders and Court Action - In addition to examinations and investigations of expressly authorized by law, the Commissioner may examine and investigate insurance matters to see if any person has violated any insurance law or to secure information useful in the lawful administration of his or her duties.

If the Commissioner determines, after notice and hearing, that any person is transacting insurance in an illegal, improper or unjust manner or is failing to pay losses and obligations when they become due, he or she may order that person to discontinue the illegal, improper or unjust manner of transacting insurance. If that person fails or refuses within 20 days after notice to obey the order, the Commissioner may revoke any license, and may apply to the

circuit court to enforce the order. The court may also appoint a receiver to take charge of the affairs and property of that person, and make any further orders as necessary. (33-2-11)

Discretionary Refusal, Revocation or Suspension of Insurer License - The Commissioner may after notice and hearing refuse to renew, or may revoke or suspend the license of an insurer if the insurer:

- Violates any provision of this Chapter other than those as to which refusal, suspension or revocation is mandatory;
- Fails to comply with any lawful rule, regulation or order of the Commissioner;
- Is transacting insurance in an illegal, improper or unjust manner;
- Is found by the Commissioner to be in an unsound condition or in such condition as to render its further transaction of insurance in West Virginia hazardous to its policyholders or to the people of West Virginia;
- Compels insureds under its policies to accept less than the amount due them or to bring suit against it to secure full payment when it has no substantial defense;
- Refuses to be examined or to produce its accounts, records and files for examination by the Commissioner when required;
- Fails to pay any final judgment rendered against it in West Virginia within 30 days after the judgment became final or time for appeal expired, whichever is later;
- Fails to pay when due to the state of West Virginia any taxes, fees, charges or penalties required by this Chapter.

In lieu of refusing to renew, revoking or suspending the license of an insurer in any case except where such action is mandatory, the Commissioner may, by order, require the insurer to pay to the state of West Virginia a penalty in a sum not exceeding $10,000, and upon the failure of the insurer to pay such penalty within 30 days after notice thereof, the Commissioner may revoke or suspend the license of such insurer.

When any license has been revoked or suspended or renewal thereof refused, the Commissioner may reissue, terminate the suspension or renew such license when he is satisfied that the conditions causing such revocation, suspension or refusal to renew have ceased to exist and are unlikely to recur. (33-3-11)

Transaction of Insurance by Unauthorized Insurer - Any insurer engaged in any act which constitutes the unauthorized transaction of insurance may, after notice and hearing, be fined by the Commissioner a sum not to exceed $20,000 for each unauthorized act or transaction of unauthorized insurance. In addition, such insurer may be assessed restitution by the Insurance Commissioner in an amount sufficient to reimburse any and all insureds for the unpaid claims, if, after notice and hearing, the Commissioner finds that the unauthorized insurer has failed to pay claims of its insureds in accordance with the terms of the contracts. (33-44-7)

Definitions, Restrictions, & Responsibilities

Licensed and Unlicensed Companies

License Required - No person may act as an insurer and no insurer may transact insurance in West Virginia unless authorized by a valid license issued by the Commissioner (except for transactions expressly permitted under the insurance laws).

No license is required for an insurer, formerly holding a valid license, to enable it to investigate and settle losses under its policies lawfully written in West Virginia while the license was in effect, or to liquidate assets and liabilities of the insurer (other than the collection of new premiums) as may have resulted from its former authorized operations in West Virginia.

An insurer not transacting new insurance business in West Virginia but continuing collection of premiums on and servicing of policies remaining in force as to residents of or risks located in West Virginia, is transacting insurance in West Virginia for the purpose of premium and annuity tax requirements but is not required to have a license.

Any officer, director, producer, representative or employee of any insurer who willfully authorizes, negotiates, makes or issues any insurance contract in violation of this section will be subject to the provisions of the Unauthorized Insurers Act (Article 44). (33-3-1)

Domestic, Foreign, Alien, Nonadmitted, and Unauthorized Companies

"Admitted insurer" means any insurer licensed to do insurance business in this state.

"Nonadmitted Insurer" means an insurer not licensed to do insurance business in this state.

"Eligible Surplus Lines Insurer" means a nonadmitted insurer with which a surplus lines licensee may place surplus lines insurance.

"Domestic Insurer" means an insurer formed under the laws of West Virginia

"Foreign Insurer" means an insurer formed under the laws of the United States or of another state of the United States.

"Alien Insurer" means an insurer formed under the laws of a country other than the United States.

"Stock Insurer" means an incorporated insurer with capital divided into shares and owned by its shareholders.

"Mutual Insurer" means an incorporated insurer without permanent capital stock and the governing body of which is elected by the policyholders, and is typically owned by its policyholders.

"Unauthorized Insurer" means a person or insurer engaged in the transaction of insurance without a license in force pursuant to the laws of this state unless exempted by the insurance

laws of this state, or any person assisting an unauthorized insurer. (33-1-6, 7, 8, 18, 19; 33-12C-3; 33-44-3)

Selling, Soliciting, and Negotiating Insurance

"Sell" means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurance company.

"Solicitation" and "solicit" mean attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular company.

"Negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms or conditions of the contract, provided that the individual engaged in the negotiation either sells insurance or obtains insurance from insurers for purchasers.

No producer or surplus lines broker may knowingly place any coverage in an insolvent insurer. (33-12-2; 33-12-21)

Insurance Producers, Brokers and Solicitors Defined

- **Insurance Producer** – An individual appointed by an insurer to solicit, negotiate, or effect insurance contracts on its behalf. (33-1-12)
- **Insurance Broker** – An individual who represents the buyer, rather than the insurance company, and tries to find the buyer the best policy by comparison shopping. (33-1-14)
- **Insurance Solicitor** – An individual appointed and authorized by a producer to solicit and receive applications for insurance as a representative of that producer. (33-1-13)
- **Surplus Lines Licensee** – An individual licensed to place insurance on properties, risks or exposures located or to be performed in this state with nonadmitted insurers eligible to accept such insurance. Wherever the term "excess lines broker" appears, it will mean surplus lines licensee. (33-12C-3(t))

Surplus Lines – Nonadmitted Insurance Act

Surplus lines (formerly known as excess lines) insurance means any property and casualty insurance in this state on risks or exposures in this state, permitted to be placed by a surplus lines licensee with a nonadmitted insurer eligible to accept such business. A nonadmitted insurer means an insurer not licensed to do insurance business in this state. Surplus lines insurance may be placed by a surplus lines licensee if:

- The insurer is an eligible surplus lines insurer.
- The insurer is authorized to write the type of insurance desired in its state of domicile.

- The full amount of insurance cannot be obtained from admitted insurers in this state even after a "diligent search" is made by the producer among the admitted insurers. (33-12C)

This section is also known as The Nonadmitted Insurance Act, the purposes of which include:

- Protecting persons seeking insurance in this state;
- Permitting surplus lines insurance to be placed with reputable and financially sound nonadmitted insurers and exported from this state;
- Establishing a system of regulation which will permit orderly access to surplus lines insurance in this state and encourage admitted insurers to provide new and innovative types of insurance available to consumers in this state;
- Providing a system through which persons may purchase insurance other than surplus lines insurance from nonadmitted insurers;
- Protecting revenues in this state; and
- Providing a system which subjects nonadmitted insurance activities in this state to the jurisdiction of the Insurance Commissioner and state and federal courts in suites by or on behalf of the state. (33-12C-1, 2, 3, 5)

Surplus Lines Licensing - The Commissioner may issue a surplus lines license to a qualified holder of a current property and casualty individual producer license but only when the individual has:

- Paid a $200 annual fee to the Commissioner
- Submitted a completed license application
- Passed a qualifying examination approved by the Commissioner
- If a resident, establishes and continues to maintain an office in this state (33-12C-8)

Surplus Lines Tax - A tax of 4% of the gross premium of a surplus lines policy must be collected by the surplus lines licensee. This tax is paid by the policyholder. This tax provides additional revenue for municipal policemen's and firemen's pension and relief funds, and for additional revenue for volunteer fire companies. The money collected is deposited into a special account in the state treasury designated "Municipal Pensions and Protection Fund." (33-12C-7)

Transaction of Insurance - For purposes of this article, any of the following acts in this state effected by mail or otherwise by a nonadmitted insurer or by any person acting with the actual or apparent authority of the insurer, on behalf of the insurer, is deemed to constitute the transaction of an insurance business in or from this state:

- The making of or proposing to make, as an insurer, an insurance contract;
- The making of or proposing to make, as guarantor or surety, any contract of guaranty or suretyship as a vocation and not merely incidental to any other legitimate business or activity of the guarantor or surety;
- The taking or receiving of an application for insurance;

- The receiving or collection of any premium, commission, membership fees, assessments, dues or other consideration for insurance or any part thereof;
- The issuance or delivery in this state of contracts of insurance to residents of this state or to persons authorized to do business in this state;
- The solicitation, negotiation, procurement or effectuation of insurance or renewals thereof;
- The dissemination of information as to coverage or rates, or forwarding of applications, or delivery of policies or contracts, or inspection of risks, the fixing of rates or investigation or adjustment of claims or losses or the transaction of matters subsequent to effectuation of the contract and arising out of it, or any other manner of representing or assisting a person or insurer in the transaction of risks with respect to properties, risks or exposures located or to be performed in this state;
- The transaction of any kind of insurance business specifically recognized as transacting an insurance business within the meaning of the statutes relating to insurance;
- The offering of insurance or the transacting of insurance business; or
- Offering an agreement or contract which purports to alter, amend or void coverage of an insurance contract. (33-12C-3(u))

West Virginia Valued Policy Law

For a total loss by fire or otherwise, all insurers issuing policies providing fire insurance on ***real property*** located in West Virginia are liable for the whole amount of insurance stated in the policy for that real property. For a partial loss by fire or otherwise of the real property insured, the liability will be for the total amount of the partial loss, not to exceed the whole amount of insurance upon the real property as stated in the policy. This section does not apply where the insurance has been procured from two or more insurers covering the same interest in real property. (33-17-9)

West Virginia Comparative Negligence Law

On March 5, 2015 Governor Tomblin signed HB 2002 into law, changing West Virginia's joint and several liability standard – to one of comparative fault. Until now, defendants in West Virginia faced joint and several liability which meant that they could be responsible for more damages than those which actually reflect their percentage of fault. HB 2002 abolished joint and several liability in West Virginia and set forth the new comparative fault standard to be used in computing actions for damages. The Code sections established by HB 2002 set forth the definition of West Virginia's new ***modified comparative fault standard*** and provide that the allocation of damages applicable to each person are to be in direct proportion to that person's percentage of fault.

In most situations, a defendant will only be liable for the percentage of the plaintiff's damages attributed to that defendant's conduct. In addition, fault can be attributed not only to parties, but also to nonparties. In many instances, these changes will reduce the amount of damages for which a defendant ultimately will be responsible.

House Bill 2002 also creates a standard wherein juries may consider the fault of nonparties. Specifically, in cases in which a plaintiff is seeking damages for personal injury, property damage, or wrongful death, the jury will now allocate fault to parties, as well as nonparties, in direct proportion to that person or entity's percentage of fault. The new West Virginia Code provisions created by House Bill 2002 establish procedures for defendants to identify nonparties to whom fault may be allocated.

The plaintiff will be barred from recovery if he or she is found to be more than 50% at fault. Previously, a plaintiff's fault could not reach or exceed 50%. In addition, if a plaintiff is found to be less than 50% at fault, his or her recovery will be reduced in proportion to the fault allocated to him. In situations where the plaintiff is found to be 50% at fault, the practical effect is that the plaintiff's recovery ultimately will be reduced in proportion to his or her degree of fault in 50-50% situations because with several liability, defendants will only be liable up to their percentage of fault.

In any civil action, a defendant is not liable for damages that the plaintiff suffers as a result of the negligence or gross negligence of a defendant if such damages arise out of the plaintiff's commission, attempt to commit or fleeing from the commission of a felony criminal act if the plaintiff has been convicted of the felony, or if deceased, the jury makes a finding that the decedent committed the felony.

With the adoption of ***several liability***, each defendant will only be liable for the amount of compensatory damages owed to the plaintiff proportionate to his or her percentage of fault. For instance, if John is defendant #1 and is found to be 60% at fault and Joan, defendant #2 is found to be 40% at fault for the plaintiff's compensatory damages in the amount of $100,000, a judgment in the amount of $60,000 will be entered against John and $40,000 entered against Joan. Under the joint liability theory previously recognized in West Virginia, both defendants could both be liable for the entire $100,000 judgment.

However, if one defendant is found to be financially insolvent, the other defendant may ultimately be responsible for insolvent defendant's portion of the judgment. Within ***one year after a judgment becomes final, a plaintiff may move to reallocate any amount he or she was unable to collect from a liable defendant among the other parties found to be liable.***

House Bill 2002 does, however, provide for several instances in which joint liability may be imposed including a defendant whose driving under the influence is a proximate cause of the plaintiff's damages, a defendant whose criminal conduct is a proximate cause of the plaintiff's damages, and a defendant whose illegal disposal of hazardous waste is a proximate cause of the plaintiff's damages. In addition, joint liability may be imposed on defendants engaged in a conspiracy.

The new West Virginia Code section created by House Bill 2002 related to several liability does not apply to the Governmental Tort Claims and Insurance Reform Act, the Uniform Commercial Code, and the Medical Professional Liability Act.

In summary, the new law provides:

- the allocation of damages applicable to each entity are to be in direct proportion to that entity's percentage of fault;
- liability for all compensatory damages will be only several, and not joint;
- joint liability is applicable where conscious conspiracy between two or more defendants;
- nonparties may be included in the consideration of allocation of fault for the harm;
- burden of proof for establishing comparative fault is on the party seeking to do so;
- provision for re-allocation of proportionate shares by trial court upon plaintiff's motion alleging a partially uncollectible verdict within one year after final judgment;
- a plaintiff cannot recover damages resulting from his or her commission of a felony criminal act;
- applicability to all actions arising or accruing on or after the effective date of May 25, 2015. (55-7-13(a-d))

Obtaining and Maintaining a License

Purpose/Requirements

No person in West Virginia may act as or hold himself or herself out to be an insurance producer, broker or solicitor nor in any manner solicit, negotiate, make or procure insurance covering subjects of insurance resident, located or performed in West Virginia, unless properly licensed. No producer, broker or solicitor (or any representative or employee) may solicit or take application for, negotiate, procure or place for others any kind of insurance unless properly licensed. No insurer may accept any business from any insurance producer who does not then ***hold an appointment*** as a producer for that insurer. (33-12-3)

Any person who solicits an application for insurance in West Virginia will be considered the agent of the insurer and not the agent of the insured in any controversy between the insured or a beneficiary and the insurer issuing any policy on the application. (33-12-22)

License means a document issued by this state's Insurance Commissioner authorizing a person to act as an insurance producer for the lines of authority specified in the document. The license itself does not create any authority, actual, apparent or inherent, in the holder to represent or commit an insurance carrier. (33-12-2)

Qualifications for License

Producers and Agencies - An ***individual*** applying for a resident insurance producer license must make application to the Insurance Commissioner and declare under penalty of refusal, suspension or revocation of the license that the statements made in the application are true, correct and complete. Before approving the application, the Insurance Commissioner will find that the individual:

- Is a resident of the state of West Virginia

- Is at least 18 years of age;
- Has not committed any act that is a ground for denial, suspension or revocation;
- Where required by the Commissioner, has completed a prelicensing course of study for the lines of authority for which the person has applied;
- Has paid the required fees as set forth by this article;
- Has successfully passed the examinations for the lines of authority applied for:
- On or after June 1, 1990, no solicitor's license will be issued that is not a renewal of an existing license;
- Does not intend to use the license principally for ***controlled business***, meaning, in the case of life or accident and sickness insurance, procuring insurance on himself, members of his family or his relatives; or as to insurance other than life and accident and sickness, upon his property or insurable interests or those of his family or his relatives or those of his employer, employees or firm, or corporation in which he owns a substantial interest, or of the employees of such firm or corporation, or on property or insurable interests for which the applicant or any such relative, employer, firm or corporation is the trustee, bailee or receiver (For the purposes of this provision, a vendor's or lender's interest in property sold or being sold under contract or which is the security for any loan, will not be deemed to constitute property or an insurable interest of such vendor or lender.)
- Satisfies the Commissioner that he is trustworthy and competent (The Commissioner may test the competency of an applicant for a license under this section by examination. Each examinee must pay an examination fee for each examination to the Commissioner who deposits the fee into the state treasury for the benefit of the state fund, general revenue. The Commissioner may designate an independent testing service to prepare and administer the exam under the direction and approval of the Commissioner, and examination fees charged by that service must be paid by the applicant directly to the service.)
- New agents first licensed on or after July 1, 1999, must complete a program of insurance continuing education as established by the Insurance Code.

A ***business entity acting as an insurance agency*** is required to obtain an insurance producer license. Application must be made using the uniform business entity application. Before approving the application, the Insurance Commissioner will find that:

- The insurance agency has disclosed to the Insurance Commissioner all officers, partners, and directors, whether or not they are licensed as insurance producers;
- The insurance agency's officers, directors, or partners are trustworthy, of good moral character, and of good business reputation;

- The insurance agency has paid the fees set forth as set forth in this article;
- The insurance agency has designated an individual licensed producer who is an officer, partner, or director responsible for the insurance agency's or business entity's compliance with the insurance laws and rules of this state;
- The insurance agency has registered with the Commissioner the name of each natural person who, as an officer, director, partner, owner, or member of the agency, is acting as and is licensed as an insurance producer;
- The insurance agency has registered with the Commissioner the name of each natural person who, as an officer, director, partner, owner, or member of the insurance agency or business entity, is acting as and is licensed as an insurance producer;
- The insurance agency or business entity has registered with the Commissioner at least one individual who holds a valid insurance producer license for the line or lines of authority requested in the application;
- If the insurance agency's filing status is nonresident, the insurance agency or business entity has complied with the qualification requirements of section twelve of this article; and
- An insurance agency may qualify as a resident if the agency has its principal office in this state. (33-12-6)

Personal Liability of Insurance Producer - Any producer who participates directly or indirectly in effecting any insurance contract (except authorized reinsurance) upon any subject of insurance resident, located or to be performed in West Virginia, where the insurer is not licensed to transact insurance in this state, will be personally liable for that contract as though the producer were the insurer. This section does not apply to surplus lines insurance, ocean marine insurance or marine protection and indemnity insurance. (33-12-20)

Issuance of License - Unless denied licensure pursuant to the Insurance Code, individuals who have met the requirements will be issued an insurance producer license. An insurance producer may receive qualification for a license in one or more of the following lines of authority:

- Life Insurance - Coverage on human lives including benefits of endowment and annuities, and may include benefits in the event of death or dismemberment by accident and benefits for disability income;
- Accident and Health or Sickness - Insurance coverage for sickness, bodily injury or accidental death and may include benefits for disability income;
- Property Insurance Coverage – Coverage for the direct or consequential loss or damage to property of every kind;
- Casualty Insurance Coverage - Coverage against legal liability, including that for death, injury or disability or damage to real or personal property;

- Variable Life And Variable Annuity Products - Insurance coverage provided under variable life insurance contracts and variable annuities;
- Personal Lines - Property and casualty insurance coverage sold to individuals and families for primarily noncommercial purposes;
- Credit - Limited line credit insurance; or
- Any other line of insurance permitted under state laws or regulations.

An insurance producer license will remain in effect unless revoked or suspended as long as the required fee is paid and education requirements for resident individual producers are met by the due date.

An individual insurance producer who allows his or her license to lapse may, within 12 months from the due date of the renewal fee, reinstate the same license without the necessity of passing a written examination. However, a penalty in the amount of double the unpaid renewal fee will be required for any renewal fee received after the due date.

An individual licensed insurance producer who is unable to comply with license renewal procedures due to military service or some other extenuating circumstance (e.g., a long-term medical disability) may request a waiver of those procedures. The producer may also request a waiver of any examination requirement or any other fine or sanction imposed for failure to comply with renewal procedures.

The license will contain the licensee's name, address, personal identification number, and the date of issuance, the lines of authority, the expiration date and any other information the Insurance Commissioner considers necessary.

Licensees must inform the Insurance Commissioner by any means acceptable to the Insurance Commissioner of a change of address or residency ***within 30 days*** of the change. Failure to timely inform the Insurance Commissioner of a change in legal name, residency or address may result in a penalty. The Commissioner will maintain the mailing address of each agent, insurance agency, solicitor and service representative on file. (33-12-9)

Licensing of Nonresident Producers

Unless denied licensure pursuant to the Insurance Code, a nonresident person will receive a nonresident producer license if:

1. The person is currently licensed as a resident and in good standing in his or her home state;
2. The person has submitted the proper request for licensure and has paid the fees required by this Chapter;
3. The nonresident person holds a similar license that is awarded on the same basis in the nonresident's home state and for the same line or lines of authority applied for in this state;

4. The person has submitted or transmitted to the Insurance Commissioner the application for licensure that the person submitted to his or her home state, or in lieu of the same, a completed uniform application; and
5. The person's home state awards nonresident producer licenses to residents of this state on the same basis.

An insurance agency may qualify as a nonresident if the agency has its principal office located in another state.

The Insurance Commissioner may verify the producer's licensing status through the producer database maintained by the national association of Insurance Commissioners, its affiliates or subsidiaries.

A nonresident producer who moves from one state to another state or a resident producer who moves from this state to another state must file a change of address and provide certification from the new resident state ***within 30 days*** of the change of legal residence. No fee or license application is required.

If the insurance department of the nonresident insurance producer's resident state suspends, terminates, or revokes the producer's insurance license in that state, the nonresident insurance producer must notify the Commissioner and return the West Virginia nonresident license.

Notwithstanding any other provision of this article, an individual licensed as a surplus lines producer in his or her home state will receive a nonresident surplus lines producer license pursuant to this section.

Notwithstanding any other provision of this article, an individual licensed as a limited line credit insurance or other type of limited lines producer in his or her home state will receive a nonresident limited lines producer license, pursuant to this section, granting the same scope of authority as granted under the license issued by the producer's home state. (33-12-12)

Company Requirements

No insurer may accept any business from or pay any commission to any individual insurance producer who does not then hold an appointment as an individual insurance producer for such insurer pursuant to this article. (33-12-3(d))

Additional Fire & Casualty Premium Tax - For the purpose of providing additional revenue for municipal policemen's and firemen's pension and relief funds and the teachers retirement system reserve fund and for volunteer and part volunteer fire companies and departments, there is an additional premium tax equal to 1% of taxable premiums for fire insurance and casualty insurance policies. All moneys collected from this additional tax is deposited into a special account in the state treasury designated "Municipal Pensions and Protection Fund." (33-3-14d)

Fingerprinting

In furtherance of the national goal of promoting uniformity and reciprocity among the states with regard to producer licensing, this section sets forth the requirements to obtain access to the Federal Bureau of Investigation Criminal Justice Information Services Division criminal history record information and to secure information or reports from the Federal Bureau of Investigation Criminal Justice Information Services Division. This section is sets forth the applicability of the criminal history record check to applicants for a home state insurance producer license.

The following terms have the meanings ascribed in this section, unless a different meaning is clearly required by the context:

- "Applicant" means a natural person applying for:
    - An initial home state license as an insurance producer;
    - An additional line of authority under an existing home state insurance producer license where a criminal history record check has not been obtained; or
    - A resident insurance producer license under change of home state provisions.

  Applicant does not mean a person applying for renewal or continuation of a home state insurance producer license or a nonresident insurance producer license.

- "Fingerprint" means an impression of the lines on the finger taken for the purpose of identification. The impression may be obtained electronically or in ink converted to an electronic format.

In order to make a determination of license eligibility, the Commissioner is authorized to require fingerprints of applicants and to submit the fingerprints and the fee required to perform the criminal history record checks to the West Virginia State Police and to the Federal Bureau of Investigation for the state and national criminal history record checks.

The Commissioner will require a criminal history record check on each applicant in accordance with this section. The Commissioner will require each applicant to submit a full set of fingerprints, including a scanned file from a hard copy fingerprint, in order for the Commissioner to obtain and receive national criminal history records from the Federal Bureau of Investigation Criminal Justice Information Services Division.

The Commissioner will collect a fee from each applicant in an amount established by rule. The amount of the fee must be sufficient to cover:

- The cost of the collection and transmittal of fingerprints by persons, including local law enforcement agencies that are approved by the Commissioner to capture fingerprints, to the West Virginia State Police and the Federal Bureau of Investigation; and
- The cost of any amounts charged by the State Police and the Federal Bureau of Investigation to perform the criminal history record checks.

The Commissioner may contract for the collection and transmission of fingerprints authorized under this section and may order that the fee for collecting and transmitting fingerprints be payable directly by the applicant to the contractor. The Commissioner is authorized to receive criminal history record information directly from the Federal Bureau of Investigation, in lieu of via transmission of the information from the Federal Bureau of Investigation to the West Virginia State Police.

The Commissioner will treat and maintain an applicant's fingerprints and any criminal history record information obtained under this section as confidential and will apply security measures consistent with the Federal Bureau of Investigation Criminal Justice Information Services Division standards for the electronic storage of fingerprints and necessary identifying information. The Commissioner will limit the use of records solely to the purposes authorized in this section. The fingerprints and the criminal history record information in the custody of the Commissioner are not subject to subpoena, other than one issued in a criminal action or investigation; are confidential by law and privileged; and are not subject to discovery or admissible in evidence in any private civil action.

The Commissioner will promulgate emergency rules pursuant to the provisions of this code as are necessary for the administration of this section, including rules governing the issuance of provisional producer licenses pending receipt of the criminal background check. (33-12-37; 114-2A)

Termination of License

Expiration and Renewal of License - All licenses of producers, solicitors, brokers and surplus line brokers expire on the last day of the licensee's birth month two years after the date of issuance. The Commissioner biennially renews the license of all licensees who qualify and apply for license renewal. The renewal fee for the two year license is $50 ($25 for each license year). (33-12-17)

Nonrenewal, Revocation, Suspension or Refusal to Renew - The Commissioner may examine and investigate the business affairs and conduct of every person applying for or holding an insurance producer license to determine whether such person has been or is engaged in any violation of the insurance laws or rules of this state or has engaged in unfair or deceptive acts or practices in any state.

A producer license may be placed on probation, revoked, suspended or non-renewed when the licensee has violated any of the insurance laws or rules of this state or has engaged in any unfair or deceptive acts or practices. In addition to or in lieu of any revocation, suspension or nonrenewal of a license, an individual may, after hearing, be subject to a civil penalty in a sum not to exceed $5,000. Upon the failure of the licensee to pay such penalty within 30 days, the Commissioner will revoke or suspend such license.

In the event that the action by the Insurance Commissioner is to nonrenew or to deny an application for a license, the Commissioner will notify the applicant or licensee and advise, in writing, the reason for the denial or nonrenewal of the application or license. The applicant or

licensee may make written demand upon the Commissioner within 10 days for a hearing before the Commissioner to determine the reasonableness of the denial or nonrenewal. The hearing will be held within 45 days. The Commissioner must give at least 15 days notice of the time and place of the hearing to all persons directly affected by the hearing.

The producer's license of a business entity may be placed on probation, suspended, revoked, refused or have civil penalty or any combination of actions, if the Insurance Commissioner finds, after hearing, that an individual licensee's violation was known or should have been known by one or more of the partners, officers or managers acting on behalf of the partnership, corporation, or other business entity and the violation was neither reported to the Commissioner nor corrective action taken. (33-12-24)

Limitation of License

An insurance producer must deal only with a licensed insurer, broker or solicitor. No producer may accept any risk, place any insurance or issue any policy except with an insurer licensed in West Virginia. The producer ***must also be appointed and licensed*** by that insurer. A producer may not solicit, market, sell or transact any business of any kind on behalf of any insurer until after the producer has been appointed as producer for that insurer, and the appointment has been approved by the Commissioner. No producer may accept any contract of insurance from any broker not licensed in West Virginia. (33-12-18)

A solicitor must act only through an appointing producer. A solicitor may solicit and receive applications for insurance only for the licensed producer who appointed the solicitor, and must report all business through that producer. The expiration, cancellation, suspension or revocation of the license of the appointing producer will automatically expire, cancel, suspend or revoke the solicitor's license, and the appointing producer may cancel a solicitor's license at any time by written request to the Commissioner. No producer may apply for licenses for more than two solicitors. No solicitors are permitted for life insurance producers. (33-12-19)

It is unlawful for any person to, directly or indirectly, represent, aid, counsel, opine, administer, assist in any manner or capacity or otherwise act as an agent for or on behalf of an unauthorized insurer in the unauthorized transaction of insurance. Any person who represents, aids or assists, in any manner or capacity, an unauthorized insurer in violation of this article will be subject to the provisions and penalties set forth in this article. (33-44-4(b))

Education Requirements

New insurance producers first licensed on or after July 1, 1989, must complete a program of continuing education. The current program requirements are outlined below:

- The ***Board of Insurance Producer Education*** consists of the Commissioner of Insurance and six members appointed by the Commissioner: two licensed property and casualty insurance producers, one licensed life insurance producer, one licensed health and accident insurance producer, one representative of a domestic insurer, and one representative of a foreign insurer. Each member serves a term of three

years and is eligible for reappointment. The Board must include companies or producers for companies representing at least 2/3 of net written state insurance premiums.

- The Board of Insurance Producer Education sets the criteria for a program of insurance education and submits the proposal to the Commissioner for approval before December 31st of each year. The Commissioner and the Board, under standards established by the Board, may approve any course or program of instruction developed or sponsored by an authorized insurer, accredited college or university, producer's association, insurance trade association, or independent program of instruction that presents the criteria and the number of hours that the Board and Commissioner determine appropriate.
- Individual insurance producers licensed to engage in the sale of property and casualty insurance must complete 24 hours of continuing insurance education biennially (every two years) including 3 hours in the subject of ethics. Individual insurance producers who exceed the minimum continuing education requirement for the biennial reporting period may carry-over a maximum of six credit hours only into the next reporting period. The Board of Insurance Education will develop and oversee programs of continuing education. (33-12-8)

Exemptions – Continuing education requirements do not apply to:

- Persons holding resident licensed for any kind of insurance for which an examination is not required
- Persons selling only limited lines credit insurance and limited lines insurance
- Individual insurance producers whose licenses have expired
- Individual insurance producers who have voluntarily cancelled their licenses
- Nonresident individual insurance producers
- Adjusters

Individual insurance producers newly licensed on or after July 1 of the second year of a biennium are exempt from continuing insurance education requirements only for the biennium in which the licensed as issued. (114-42-4)

Proof of Completion – Upon completion of a continuing insurance education course, the provider must certify to the Commissioner the names of all individual insurance producers who satisfactorily completed the course. A continuing education attendance certification roster must be mailed by the provider to the Commissioner within 30 days after completion of the course. The provider must furnish a certificate of satisfactory completion to the individual insurance producer completing the course. The individual insurance producer must retain a copy of the certificate for not less than four years from the date the course is completed. The provider must also retain records or each course completed for not less than four years. (114-42-7)

Mandatory Reporting Requirements

Reporting of Actions – A producer must report to the Insurance Commissioner any administrative action taken against the producer in another jurisdiction or by another governmental agency in this state ***within 30 days*** of the final disposition of the matter. This report must include a copy of the order, consent to order or other relevant legal documents. Within 30 days of the initial pretrial hearing date, a producer must report to the Insurance Commissioner any criminal prosecution of the producer taken in any jurisdiction. The report must include a copy of the initial complaint filed, the order resulting from the hearing and any other relevant legal documents. (33-12-34)

Fraud - A person engaged in the business of insurance having knowledge or a reasonable belief that fraud or another crime related to the business of insurance is being, will be or has been committed must provide to the Commissioner the information required by, and in a manner prescribed by the Commissioner. The Commissioner may prescribe a reporting form to facilitate reporting of possible fraud or other offenses related to the business of insurance for use by persons other than those persons referred to in this section. (33-41-5)

Unfair Trade Practices

The acts and practices described in this section are defined as unfair methods of competition and unfair or deceptive acts or practices by the West Virginia Insurance Code. (33-11-4)

Unfair Claim Settlement Practices

No person may commit or perform with such frequency as to indicate a general business practice any of the following:

- Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue
- Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies
- Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies
- Refusing to pay claims without conducting a reasonable investigation based upon all available information
- Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed
- Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear
- Compelling insureds to bring lawsuits to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in the suit, when insureds have made claims for amounts reasonably similar to the amounts ultimately recovered

- Attempting to settle a claim for less than the amount to which a reasonable man would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application
- Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of the insured
- Making claims payments to insureds or beneficiaries not accompanied by a statement stating the coverage under which payments are being made
- Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration
- Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information
- Failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage
- Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement (33-11-4(9); 114-14)

File and Record Documentation - The insurer's claim files will be subject to examination by the Commissioner or by his or her duly appointed designees. Such files must contain all notes and work papers pertaining to the claim in such detail that pertinent events and the dates of such events can be reconstructed. All communications and transactions emanating from or received by the insurer must be dated by the insurer. A notation of the substance and date of all oral communications must be contained in the claim file. Insurers must either make a notation in the file or retain a copy of all forms mailed to claimants. (114-14-3)

Representation of Policy Provisions and Benefits:

Failure to disclose pertinent policy provisions - No person may knowingly fail to fully disclose to first-party claimants all pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented.

Concealment of pertinent policy provisions - No person may knowingly conceal from first-party claimants benefits, coverages or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim.

Coercive statements - No person may make statements which indicate that the rights of a claimant may be impaired if a form or release is not completed within a given period of time unless the statement is given for the purpose of notifying the claimant of the provisions of a statute of limitation or of a policy or contract time limit.

Time limit for notification of claim - Except where a time limit is specified by statute or legislative rule, no insurer may require a first-party claimant to give notification of a claim or proof of claim within a specified time.

Releases - No person may ask a first-party claimant to sign a release that extends beyond the subject matter which gave rise to the claim payment. No insurer may issue any check or draft, in partial settlement of a loss or claim under a specific coverage, that contains language which releases the insurer or it's insured from its total liability. (114-14-4)

Standards for the Acknowledgment of Pertinent Communications

Acknowledgment of notices of claims - Every insurer, upon receiving notification of a claim must, ***within 15 working days***, acknowledge the receipt of such notice unless full payment is made within such period of time. If an acknowledgment is made by means other than writing, an appropriate notation of such acknowledgment must be made in the claim file of the insurer and dated. Notification given to an agent of an insurer will be considered notification to the insurer.

Answer of inquiries from Insurance Commissioner - Every insurer, producer or other licensee, upon receipt of any inquiry other than a notice of third-party administrative complaint from the Insurance Commissioner must, within 15 working days of the date appearing on the inquiry, furnish the Commissioner with a complete written response to the inquiry. A "complete written response" addresses all issues raised by the claimant or the Commissioner and includes copies of any documentation requested. This section is not intended to permit delay in responding to inquiries by the Commissioner or his or her staff in conjunction with a scheduled examination on the insurer's premises.

Replies to other pertinent communications - A reply must be made within 15 working days of receipt by the insurer to all other pertinent communications from a claimant which reasonably suggest that a response is expected.

Provisions of assistance to first-party claimants - Every insurer, upon receiving notification of a claim, must promptly provide necessary claim forms, instructions, and reasonable assistance so that first-party claimants can comply with the policy conditions and the insurer's reasonable requirements. Compliance with this section within 15 working days of notification of a claim constitutes compliance with this section. (114-14-5)

Standards for Prompt Investigations and Fair and Equitable Settlements Applicable to all Insurers

Investigation of claims - Every insurer must promptly conduct and diligently pursue a thorough, fair and objective investigation and may not unreasonably delay resolution by persisting in seeking information not reasonably required for or material to the resolution of a claim dispute. This section is not intended to conflict with the statutory requirements of the Medical Professional Liability Act, as the same relate to the assertion and investigation of medical professional liability claims.

Establishment of investigatory procedures -

- Every insurer must establish procedures to commence an investigation of any claim filed by a claimant, or by a claimant's authorized representative, within 15 working days of receipt of notice of claim.
- Every insurer must provide to every first-party claimant, or to the claimant's authorized representative, a notification of all items, statements and forms, if any, which the insurer reasonably believes will be required of such claimant, within 15 working days of receiving notice of the claim.
- A claim filed with an agent of an insurer will be deemed to have been filed with the insurer unless, consistent with law or contract, such agent promptly provides written notification to the person filing the claim that the agent is not authorized to receive notices of claim.

Duty after investigation - Within 10 working days of completing its investigation, the insurer must deny the claim in writing or make a written offer, subject to policy limits and, with respect to medical professional liability claims, subject to applicable statutory requirements set forth in the Medical Professional Liability Act.

Offers of settlement - In any case where there is no dispute as to coverage and liability, it is the duty of every insurer to offer claimants or their authorized representatives, amounts which are fair and reasonable, as shown by the insurer's investigation of the claim, providing the amounts so offered are within policy limits and in accordance with the policy provisions. No insurer may attempt to settle a claim by making a settlement offer that is unreasonably low. The Commissioner will consider any evidence offered regarding the following factors in determining whether a settlement offer is unreasonably low:

- The extent to which the insurer considered evidence submitted by the claimant to support the value of the claim;
- The extent to which the insurer considered legal authority or evidence made known to it or reasonably available;
- The extent to which the insurer considered the advice of its claims adjuster as to the amount of damages;
- The extent to which the insurer considered the opinions of independent experts;
- The procedures used by the insurer in determining the dollar amount of property damage;
- The extent to which the insurer considered the probable liability of the insured and the likely jury verdict or other final determination of the matter; and
- Any other credible evidence presented to the Commissioner that demonstrates that the final amount offered in settlement of the claim by the insurer is or is not below the amount that a reasonable person would have offered in settlement of the claim after taking into consideration the relevant facts and circumstances at the time the offer was made.

Denial of claims - No insurer may deny a claim on the grounds of a specific policy provision, condition or exclusion unless reference to such provision, condition or exclusion is included in

the denial. The denial must be given to the claimant in writing or as otherwise provided in these rules.

Records of denial of claims - If a denial of a claim is made by any other means than writing, an appropriate notation must be made in the claim file of the insurer.

Notice of necessary delay in investigating claims - If the insurer needs more than 30 calendar days from the date that a proof of loss from a first-party claimant or notice of claim from a third-party claimant is received to determine whether a claim should be accepted or denied, it must so notify the claimant in writing within 15 working days after the 30-day period expires. If the investigation remains incomplete, the insurer must provide written notification of the delay to the claimant every 45 calendar days thereafter until the investigation is complete. All such notifications must set forth the reason(s) additional time is needed for investigation. Where there is a reasonable basis supported by specific information available for review by the Commissioner that a claimant has fraudulently caused or contributed to the loss, the insurer is relieved from the requirements of this section; provided that the insurer must notify the claimant of the acceptance or denial of the claim within a reasonable time allowing for full investigation. Nothing contained in this section requires an insurer to disclose any information that could reasonably be expected to alert a claimant to the fact that the subject claim is being investigated as a suspected fraudulent claim.

Liability of others - Insurers may not refuse to settle first-party claims on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions.

Denial of claims for failure to exhibit property - No insurer may deny a claim for failure to exhibit the insured property without proof of demand by the insurer and refusal by the claimant to exhibit said property.

Separation of claims - In any case where there is no dispute as to one or more elements of a claim, payment for such element(s) must be made notwithstanding the existence of disputes as to other elements of the claim where such payment can be made without prejudice to either party.

Time for payment of claims - Every insurer must pay any amount finally agreed upon in settlement of all or part of any claim not later than 15 working days from the receipt of such agreement by the insurer or from the date of the performance by the claimant of any condition set by such agreement, whichever is later.

Notice of applicable time limitations - No person may negotiate for settlement of a claim with a claimant who is neither an attorney nor represented by an attorney without giving the claimant written notice that the claimant's rights may be affected by a statute of limitations or a policy or contract time limit. Such notice must be given to first-party claimants not less than 30 days, and to third-party claimants not less than 60 days, before the date on which such time limit expires.

Avoidance of payment - Where liability and damages are reasonably clear, no person may recommend that third-party claimants make claim under their own policies solely to avoid paying claims under an insurer's insurance policy or insurance contract.

Unreasonable travel - No person may require a claimant to travel unreasonably either to inspect a replacement motor vehicle or to obtain a repair estimate.

Compensation based on claim denials - No insurer may offer incentives or compensate its employees, agents or contractors based on savings to the insurer as a result of improperly denying the payment of claims.

Claim proceeds used to pay premiums of another policy - No insurer may deduct from a claim payment made under one policy premiums owed by the insured on another policy unless the insured consents.

Required information for claim denial notices - Any notice rejecting any element of a claim must contain the identity and the claims processing address of the insurer and the claim number. The notice must state that the claimant has the option of contacting the Commissioner. The notice must provide the Commissioner's mailing address, telephone number and web site address.

Motor vehicle repair shops - An insurer may furnish to the claimant the names of one or more conveniently located motor vehicle repair shops that will perform the repairs; however no insurer may require the claimant to use a particular repair shop or location to obtain the repairs. (114-14-6)

Excessive Charges by Producers

It has come to the attention of the West Virginia Insurance Department that a number of producers are charging excessive consideration or "fees," variously described as "administrative," "clerical," "servicing," or "placement" fees, or by other designations, in connection with insurance transactions.

The West Virginia Insurance Code defines "premium" as the consideration for insurance, by whatever name called. By the terms of this definition, any and all charges made by a producer in the taking of an application, the issuance of a policy, and any related service rendered are "premiums."

The administrative and clerical expenses attending the production of insurance and its servicing are normally considered by the insurer as an includable factor in calculating the appropriate premium to be charged for a policy of insurance.

The commissions paid a producer by the insurer represented are deemed to constitute the entire compensation due for the solicitation, negotiation, making, procuring, or servicing of a policy of insurance.

It is, therefore, the position of the Department that the charging by a producer of any extra consideration or fee, such as the above-enumerated, to defray expenses customarily allocated to and included in the policy premium, amounts to an overcharge of premium and constitutes an unfair discrimination against any insured so charged.

Any producer found to be making such charges, inasmuch as they are deemed to be unfairly discriminatory, is engaging in an unfair trade practice, and will be subject to the appropriate penalties of law governing that activity. (Information Letter 6; 33-1-17)

Rebating

Rebating is giving or offering some benefit other than those specified in the policy, such as cash, gifts, or securities, to induce a customer buy insurance.

No person may pay, allow, give or offer to pay, allow or give as an inducement to buy an insurance contract, any rebate or premiums payable on the contract, or any special favor or advantage in the dividends or other benefits, or any valuable consideration or inducement whatever not specified in the contract.

No person may give, sell, purchase or offer to give, sell or purchase as inducement to buy an insurance contract, any stocks, bonds or other securities of any insurance company or other corporation, association or partnership, or any dividends or profits, or anything of value not specified in the contract.

No insured named in a policy of insurance, or any relative, representative or employee of that insured may knowingly receive or accept any rebate, discount, abatement, credit or reduction of premium, or any special favor or advantage or valuable consideration or inducement.

This section does not prohibit the payment of commissions or other compensation to licensed agents and brokers, or prohibit any insurer from allowing or returning to its participating policyholders, members or subscribers, dividends, savings or unabsorbed premium deposits. (33-11-4(8))

The Insurance Commissioner routinely receives questions concerning whether a company or producer may give away items such as pens, key chains, clocks, and other similar items without violating the anti-rebating provisions set forth in the West Virginia Code. Likewise, the Insurance Commissioner fields many questions about how much an individual may charge for providing a referral to an insurance company or producer without violating the prohibition on referral fees.

For the purposes of the West Virginia Code the phrases "valuable consideration" and "anything of value" does not include any educational materials, promotional materials, or articles of merchandise that cost $25.00 or less, regardless of whether a policy or contract is purchased. For the purpose of determining the value of any item, an insurance company or producer must retain the original invoice for such item for five years beyond the later of the date the offer is discontinued or the date the last item is given.

Defining Nominal Fee with Respect to Referrals - The phrase "nominal fee" means a one-time fee of $25.00 or less. The payment of any referral fee cannot depend on whether the referral results in the sale or issuance of an insurance product or service. (114-70)

Boycott, Coercion and Intimidation

No person may enter into any agreement to commit, or by any concerted action commit, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of or monopoly in, the business of insurance. (33-11-4(4))

Favored Producer or Insurer; Coercion of Debtors Prohibited - It is illegal for any lender or person extending credit to:

- Require, as a condition precedent to the lending of money or extension of credit, or any renewal, that the person to whom such money or credit is extended or whose obligation the creditor is to acquire or finance, negotiate any policy or contract of insurance through a particular insurer or group of insurers or producer or broker or group of producers or brokers;
- Unreasonably disapprove the insurance policy provided by a borrower for the protection of the property securing the credit or lien (Such disapproval is unreasonable if it is not based solely on reasonable standards uniformly applied, relating to the extent of coverage required and the financial soundness and the services of an insurer. Such standards may not discriminate against any particular type of insurer, nor call for the disapproval of an insurance policy because such policy contains coverage in addition to that required);
- Require that any borrower, mortgagor, purchaser, insurer, broker, or producer pay a separate charge for the handling of any insurance policy required as security for a loan on real estate, or pay a separate charge to substitute the insurance policy of one insurer for that of another (This does not include the interest which may be charged on premium loans or premium advancements in accordance with the security instrument.);
- Use or disclose information resulting from a requirement that a borrower, mortgagor or purchaser furnish insurance of any kind on real property being conveyed or used as collateral security to a loan, when such information is to the advantage of the mortgagor, purchaser, insurer, or the insurance producer or broker complying with such a requirement.

The Commissioner may investigate the affairs of any person to whom this section applies to determine whether there has been a violation. If a violation is found, the person in violation is subjected to the same procedures and penalties that apply to other sections of this article. For purposes of this section, person includes any individual, corporation, association, partnership, or other legal entity. (33-11-5)

Misrepresentation and False Advertising

No person may make, issue, circulate, or cause to be made, issued or circulated, any estimate, circular, statement, sales presentation, omission or comparison which:

- Misrepresents the benefits, advantages, conditions or terms of any insurance policy
- Misrepresents the dividends or share of the surplus to be received on any insurance policy
- Makes any false or misleading statements as to the dividends or share of surplus previously paid on any insurance policy
- Is misleading or is a misrepresentation as to the financial condition of any person, or as to the legal reserve system upon which any life insurer operates
- Uses any name or title of any insurance policy or class of insurance policies misrepresenting its true nature
- Is a misrepresentation for the purpose of inducing or tending to induce the lapse, forfeiture, exchange, conversion or surrender of any insurance policy
- Is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any insurance policy
- Misrepresents any insurance policy as being shares of stock (33-11-4(1))

Defamation

No person may make, publish, disseminate or circulate (or aid, abet or encourage any of these actions) any oral or written statement or any pamphlet, circular, article or literature which is false, or maliciously critical of or derogatory to the financial condition of any person and which is calculated to injure that person. (33-11-4(3))

False Information and Advertising Generally

No person may make, publish, disseminate, circulate or place before the public in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster or over any radio or television station, or in any other way, an advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance or about any person conducting insurance business, which is untrue, deceptive or misleading. (33-11-4(2))

Unfair Discrimination

No person may make or permit any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable, or in any other of the terms and conditions of that contract. No person may make or permit any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium policy fees, or rates charged for any policy or contract of accident and sickness insurance or in the benefits payable, or in any of the terms or conditions of that contract, or in any other manner

whatever. As to kinds of insurance other than life and accident and sickness, no person may make or permit any unfair discrimination in favor of particular persons, or between insureds or subjects of insurance having substantially like insuring, risk and exposure factors or expense elements, in the terms or conditions of any insurance contract, or in the rate or amount of premium charge. (33-11-4(7))

Undefined Acts or Practices

If, after notice and hearing, the Commissioner determines that any person transacting insurance is engaging in this state in any method of competition or act or practice in the transaction of such insurance which is not defined in the Insurance Code, and that such method of competition is unfair or such act or practice is unfair or deceptive, the Commissioner will issue an order directing such person to cease and desist form engaging in such method of competition, act, or practice. (33-11-7)

Penalties for Violations of Unfair Trade Practices

If, after notice and hearing, the Commissioner determines that a person is in violation of unfair trade practices, he or she will issue a cease and desist order ordering that individual to stop the act or practice. The Commissioner may, at his or her discretion, order any of the following:

- The penalty for any person ***unintentionally*** engaging in any unfair method of competition, act or practice is $1,000 per act or practice not to exceed $10,000 in the aggregate.
- The penalty for any person ***intentionally*** engaging in any unfair method of competition, act or practice is $5,000 per act or practice not to exceed $100,000 in the aggregate.
- In the event a person commits an act that intentionally violates ***unfair claims settlement practices***, but the act ***is not considered to be a general business practice***, the penalty is a sum not to exceed $10,000.
- In the event ***an insurer*** commits an act that intentionally violates ***unfair claims settlement practices***, and the act ***is considered to be a general business practice***, the penalty is a sum not to exceed $250,000. In addition, restitution must be provided from the Unfair Claims Settlement Practice Trust Fund to a claimant who has suffered damages as a result of a general business practice or from an egregious act whether or not the act constituted a pattern corresponding to an unfair claim settlement practice committed with such frequency as to constitute a general business practice. Restitution provided may include actual economic damages and noneconomic damages not to exceed $10,000. Restitution may not be given for attorney fees and punitive damages.
- The penalty for ***violation of a cease and desist*** order while the order is still in effect is a sum not to exceed $10,000 for each and every act or violation.

The Commissioner may also revoke or suspend the license of any person committing any such act or violation. (33-11-6, 33-11-8)

Insurable Interest in Property

No insurance contract on property or of any interest in or from property will be enforceable as to the insurance except for the benefit of persons having an insurable interest in the things insured. Insurable interest means any actual, lawful, and substantial economic interest in the safety or preservation of the subject of the insurance free from loss, destruction, or pecuniary damage or impairment. The measure of an insurable interest in property is the extent to which the insured might be indemnified by loss, injury or impairment of the property insured. (33-6-3)

Binders

Binders or other contracts for temporary insurance may be made orally or in writing. The binder includes all the usual terms of the policy as to which the binder was given, together with applicable endorsements designated in the binder, except as superseded by the clear and express terms of the binder. No binder will be valid beyond the issuance of the policy with respect to which it was given, and no producer or insurer may issue a binder covering a period over 90 days from its effective date. If the policy has not been issued, a binder may be extended or renewed beyond the 90 days with the written approval of the Commissioner, or according to rules and regulations made by the Commissioner. This section does not apply to conditional receipts issued by life and accident and sickness insurers, or to policies of group insurance. (33-6-18)

Approval of Rates and Forms

Except where provided for fire and marine forms, no insurance policy form, group certificate form, insurance application form, rider, endorsement or other form to be attached to any policy may be delivered or issued for delivery in West Virginia by an insurer unless it has been filed with and approved by the Commissioner. However, for group insurance policies delivered outside this state, only the group certificates to be delivered or issued for delivery within the state must be filed for approval. This section does not apply to policies, riders, endorsements or forms of unique character designed for and used with relation to insurance upon a particular subject, or which relate to the manner of distribution of benefits or to the reservation of rights and benefits under life or accident and sickness insurance policies, and are used at the request of the individual policyholder. This section also does not apply to surety bond forms.

Every filing must be made not less than 60 days in advance of any delivery. At the end of the 60 days, the filed form will be deemed approved unless it has already been affirmatively approved or disapproved by the Commissioner. Approval of any form by the Commissioner constitutes a waiver of any unexpired portion of the waiting period. The Commissioner may at any time, after notice and for cause, withdraw any approval. Any order of the Commissioner

disapproving any such form or withdrawing a previous approval must state the reasons for the disapproval. (33-6-8)

No fire or marine policy, rider or endorsement to be attached to any policy, covering any risk located or to be performed in West Virginia may be delivered or issued for delivery in this state unless either:

1) Filed with and approved by the Commissioner 60 days in advance of delivery, or
2) Conforms to applicable rules approved by the Commissioner or is identical as to language to a policy, rider or endorsement approved by the Commissioner.

If the use of any such form under the provisions of clause #2 above by any insurer or by the members and subscribers of any rating organization are so extensive that in the opinion of the Commissioner the public interest requires, the Commissioner may require that such form be filed with him or her by such insurer or rating organization on behalf of its members and subscribers. This section does not apply to ocean marine policies, riders or endorsements, or to forms on specially rated inland marine risks. (33-17-8)

Filing of Rating Systems - Every insurer must file with the Commissioner every manual of classifications, territorial rate areas, rules and rates, every rating plan and every modification which it proposes to use for casualty insurance covered by this section.

Except for inland marine risks which by general custom of the business are not written according to manual rates or rating plans, every insurer must file with the Commissioner every manual, minimum, class rate, rating schedule or rating plan and every other rating rule and every modification which it proposes to use for fire and marine insurance. Specific inland marine rates on risks specially rated, made by a rating organization, must be filed with the Commissioner.

Every filing must state the proposed effective date and indicate the character and extent of the coverage contemplated. When a filing is not sent with the information on which the insurer supports the filing, and the Commissioner does not have sufficient information to determine whether it meets the requirements, he or she must require the insurer to furnish the supporting information.

An insurer may satisfy its obligation to make a filing by becoming a member of, or a subscriber to, a licensed rating organization which makes filings, and by authorizing the Commissioner to accept such filings on its behalf. However, nothing contained in this section requires any insurer to become a member of or a subscriber to any rating organization.

The Commissioner reviews filings as soon as reasonably possible after they have been made in order to determine whether they meet the requirements of this section. Subject to specified exceptions, each filing must be on file for a waiting period of 60 days before it becomes effective. Upon written application by such insurer or rating organization, the Commissioner may authorize a filing which has been reviewed to become effective before the end of the waiting period. A filing is deemed to meet the requirements of this section unless disapproved by the Commissioner within the waiting period.

Specific inland marine rates on risks specially rated by a rating organization become effective when filed and are deemed to meet these requirements until the time the Commissioner reviews the filing and as long as the filing remains in effect.

When an insurer files a request for an increase of automobile liability insurance rates in the amount of 15% or more, the Insurance Commissioner must provide notice of the increase with the office of the secretary of state to be filed in the state register and must provide interested persons the opportunity to comment on the request up to the time the Commissioner approves or disapproves the rate increase. (33-20-4)

Compensation of Licensees

Payment of Commissions - The entire commission payable by any insurer licensed to transact insurance in West Virginia on any insurance policy must be paid directly to the licensed resident producer who signs the policy. The countersigning producer must not pay any part of that commission to any person other than a licensed producer or broker. However, the portion of that commission retained by the countersigning resident producer must not be less than 10% of the gross policy premium or 50% of the commission payable by the insurer, whichever is less. Commission includes engineering fees, service fees or any other compensation incident to the issuance of a policy payable by or to any insurer, producer or broker. This section does not apply to reinsurance; life insurance; accident or health insurance; surplus lines insurance; credit insurance; any contract of insurance covering the rolling stock of any railroad or covering any vessel, aircraft or motor carrier used in interstate or foreign commerce, or any liability or other risks incident to the ownership, maintenance or operation thereof; any contract of insurance covering any property in interstate or foreign commerce, or any liability or risks incident thereto.

It is unlawful for any insurer or individual insurance producer to pay, and any person to accept, directly or indirectly, any commission. However, a licensed individual insurance producer may pay his or her commissions, or direct that his or her commissions be paid, to a business entity licensed as an insurance producer if:

- The business entity is engaged, through its licensed individual insurance producers, in conducting an insurance agency business with respect to the general public;
- If a partnership licensed as an insurance agency producer, each partner satisfies the commissioner that he or she meets the licensing qualifications established by this Code;
- If a corporation licensed as an insurance agency producer, each officer, employee or any one or more stockholders owning, directly or indirectly, the controlling interest in the corporation satisfies the Commissioner that he or she meets the licensing qualifications. This requirement does not apply to clerical employees or other employees not directly engaged in the selling or servicing of insurance;
- If a limited liability company licensed as an insurance agency producer, each officer, employee or any one or more members owning, directly or indirectly, the controlling interest in a limited liability company satisfies the Commissioner that he or she meets

the licensing qualifications. This requirement does not apply to clerical employees or other employees not directly engaged in the selling or servicing of insurance; and

- If any other business entity licensed as an insurance agency producer, approval is granted by the Commissioner.

An insurance company or insurance producer may not pay a commission, service fee, brokerage or other valuable consideration to a person for selling, soliciting or negotiating insurance in this state if that person is required to be licensed and is not so licensed.

A person may not accept a commission, service fee, brokerage or other valuable consideration for selling, soliciting or negotiating insurance in this state if that person is required to be licensed and is not so licensed.

Renewal or other deferred commissions may be paid to a person for selling, soliciting or negotiating insurance in this state if the person was required to be licensed at the time of the sale, solicitation or negotiation and was so licensed at that time. (33-12-23; 114-2-1)

Payment of Assigned Risk Plan Commissions - An insurer participating in a plan for assignment of personal injury liability insurance or property damage liability insurance on owner's automobiles or operators, approved by the Commissioner, may pay a commission to a qualified producer who is licensed to act as a producer for any insurer participating in the plan when that producer is designated by the insured as the producer of record under an automobile assigned risk plan pursuant to which a policy is issued under that plan. (33-12-27)

FAIR Plan

West Virginia Essential Insurance Coverage Act

The West Virginia Essential Insurance Coverage Act (the FAIR plan) helps provide a mechanism to establish insurance plans and make available insurance coverages to persons who do not have coverages available to them in the voluntary insurance market. (33-20A-1, 2; 114-21-1)

In many areas, for reason of poor construction, deterioration, and congestion, individual companies are unwilling to provide fire and extended coverage insurance at standard rates or at all. The federal government has established rules so insurance companies can properly provide insurance in such areas. The FAIR Plan stands for "Fair Access to Insurance Requirements." The applicant cannot be rejected just because of the environment but may be surcharged due to correctable deficiencies. The FAIR Plan began operation in November 1986 and accepts applications from all parts of West Virginia.

The West Virginia Essential Insurance Association makes fire and extended coverage insurance available to those having an insurable interest in habitational or commercial property situated in West Virginia, who are unable to secure such insurance in the voluntary insurance market. Participation is required of all insurers transacting any relevant insurance business in the state. (33-20A-3)

Definitions

For the purposes of this section, the following definitions will apply:

Producer means an individual insurance producer licensed by the Commissioner to sell property and casualty insurance in West Virginia.

Association means the West Virginia Essential Property insurance Association.

Eligible applicant means any person having an insurable interest in habitational or commercial property eligible for coverage under the provisions of this legislative rule and the Association's Plan of Organization.

Extended coverage insurance means indemnification against loss caused by the perils of fire, lightning, riot, explosion, vehicle, smoke, hail, aircraft, and wind.

Essential Property Insurance Coverage means fire and extended coverage insurance as well as any other kind of insurance that the Commissioner finds is required by the public interest but which is not readily available in the voluntary insurance market. Such a finding may only be made after a public hearing conducted by the Commissioner.

Insurer means any insurance company authorized to write and engage in writing essential property insurance coverage in West Virginia. (114-21-2)

Coverage Limits and Types

All policies issued by the Association must be for a term of one year. Policies and endorsements may be issued on forms approved by the Commissioner. (114-21-8)

Coverage for risks found insurable by the Association will be provided in an amount up to the reasonable insurable value of the property but in no event will coverage provided by the Association exceed the amount of ***$200,000 for any one residential risk or $500,000 for any one commercial risk***.

Coverage issued by the Association will limited to indemnification against loss caused by the perils of fire, lightning, riot, explosion, vehicle, smoke, hail, aircraft and wind. (114-21-9)

Application and Policy Issuance

An eligible applicant may authorize a producer to make application to the Association for essential property insurance coverage. The application must be accompanied by proof of the applicant's effort and inability to obtain essential property insurance in the voluntary market.

Upon approval by the Association of an application for coverage and upon receipt by the Association of the premium due, the Association will issue a policy and a binding receipt. The Association may decline to issue a policy and binding receipt when the applicant owes premium monies to the Association for previous insurance coverage. (114-21-11)

Inspection of Property

Upon submission to the Association of a completed application for insurance, the property requested to be insured may be physically inspected. Any physical inspection will be made without cost to the eligible applicant. A written inspection report must be made for each property inspected and a copy provided to the eligible applicant. (114-21-13)

Appeal Procedures

Any applicant for insurance, person insured by the Association or member insurer aggrieved by any ruling, action or decision of the Association or the designated servicing facility may appeal to the Board within 15 days of such ruling, action or decision. The appeal must be in writing. The Board or an Appeals Committee designated by the Board will hear and determine the appeal within 15 days after the appeal is filed. The determination of the Board may be appealed in writing to the Commissioner within 10 days of the determination. The Commissioner will render a decision concerning the appeal within 30 days. (114-21-14)

Automobile Insurance Laws and Regulations

Vehicle Registration

Every owner of a vehicle subject to registration must make application to the Division of Motor Vehicles for the registration of the vehicle in this state

The application must include a statement under penalty of false swearing that liability insurance is in effect and will continue to be in effect through the entire term of the vehicle registration period within limits which may not be less than the minimum required limits or that the applicant has qualified as a self-insurer meeting the requirements this Code and that as a self-insurer he or she has complied with the minimum security requirements.

If the Commissioner determines that the required security is not or was not in effect, he or she will suspend the vehicle owner's driver's license and revoke the vehicle registration.

If any person making an application and knowingly provides false information, false proof of security or a false statement of insurance, or if any person, including an applicant's insurance agent, knowingly counsels, advises, aids or abets another in providing false information, false proof of security, or a false statement of insurance in the application he or she is guilty of a misdemeanor and, upon conviction will be fined not more than $500, or be imprisoned for a period not to exceed 15 days, or both fined and imprisoned and, in addition to the fine or imprisonment, will have his or her driver's license suspended for a period of 90 days and vehicle registration revoked if applicable. (17A-3-3)

Automobile Financial Responsibility

The purpose of this section is to promote the public welfare by requiring every owner or registrant of a motor vehicle licensed in this state or operated in this state to maintain certain security during the registration period for the vehicle and to provide the means for the Division of Motor Vehicles, law enforcement and the judicial branch to electronically verify evidence of current insurance coverage at any time while a vehicle has a current registration or is operated on the roads and highways.

This section applies to the operation of all motor vehicles required to be registered or operated on the roads and highways to have the security in effect, with the exception of motor vehicles owned by the state, any of its political subdivisions or by the federal government.

Every owner or registrant of a motor vehicle required to be registered and licensed in this state must maintain security continuously throughout the registration or licensing period except in case of a periodic use or seasonal vehicle, in which case the owner or registrant is required to maintain security upon the vehicle only for the portion of the year the vehicle is in actual use. As used in this section, a periodic use or seasonal vehicle means a recreational vehicle, antique motor vehicle, motorcycle or other motor vehicle which is stored part of the year and used seasonally. The owner or registrant must immediately surrender the registration plate to the Division of Motor Vehicles when he or she drops the required security during the registration period.

Every nonresident owner or registrant of a motor vehicle, which is operated upon any road or highway of this state and which has been physically present within this state for more than 30 days during the preceding 365 days must thereafter maintain security as provided in effect continuously throughout the period the motor vehicle remains within this state.

No person may knowingly drive or operate upon any road or highway any motor vehicle upon which security is required unless the required security is in effect. The security may be provided by one of the following methods:

- By an ***insurance policy*** delivered or issued for the delivery in this state by an insurance company authorized to issue vehicle liability and property insurance policies in this state within limits which may not be less than the minimum requirements; or
- By qualification as a ***self-insurer***. (17D-2A-1, 2, 3)

Proof of Financial Responsibility – Effective January 1, 2016, "proof of financial responsibility" means proof of the ability to respond in damages for liability, for an accident occurring after the effective date of the proof, arising out of the ownership, operation, maintenance or use of a motor vehicle, trailer or semi-trailer in the following amounts:

- $25,000 for bodily injury or death of one person in any one accident;
- $50,000 for bodily injury or death of two or more persons in any one accident;
- $25,000 for injury or destruction of property of others in any one accident.

Prior to January 1, 2016, the minimum liability limits were $20/40/10. (17D-4-2)

Motor Vehicle Liability Policy - Motor vehicle liability policy means an "owner's policy" or an "operator's policy" of liability insurance certified as proof of financial responsibility and issued by an authorized insurance carrier for the benefit of the person named as the insured. An owner's policy of liability insurance must describe all vehicles covered, and insure the person named and any other person using the vehicles with the permission of the named insured against loss from the liability imposed by law for damages arising out of the ownership, operation, maintenance or use of the vehicles within the United States of America or the Dominion of Canada, subject to the required limits.

An operator's policy of liability insurance insures the person named against loss from the liability imposed by law for damages arising out of the use by the operator of any motor vehicle not owned by him or her, within the same limits of liability for an owner's policy of liability insurance.

The motor vehicle liability policy must state the name and address of the named insured, the coverage afforded by the policy, the premium charged, the policy period, and the limits of liability. Every motor vehicle liability policy is subject to the following provisions:

- The liability of the insurance carrier becomes absolute whenever injury or damage covered by the policy occurs, and the policy may not be cancelled as to that liability by an agreement between the insurance carrier and the insured after the injury or damage;
- The satisfaction by the insured of a judgment for the injury or damage may not be a condition precedent to the right or duty of the insurance carrier to make payment on account of the injury or damage.

The insurance carrier has the right to settle any claim covered by the policy, and (if the settlement is made in good faith) the amount is deductible from the required limits of liability. The requirements for a motor vehicle liability policy may be met by the policies of one or more insurance carriers which together meet the requirements. (17D-4-12)

Self-Insurance - Any person in whose name more than 25 vehicles are registered may qualify as a self-insurer by obtaining a certificate of self-insurance issued by the Commissioner. The Commissioner will issue a certificate of self-insurance when he or she is satisfied an applicant has the ability to pay judgments obtained against such person. The Commissioner will not issue a certificate of self-insurance unless the applicant is listed as the registered owner of the motor vehicles and the applicant files an itemized financial statement that reflects a $1 minimum in total assets. The listed assets must be wholly owned by the applicant. A self-insured applicant must notify the Commissioner upon his or her filing of a petition for bankruptcy and must comply with the provisions of this Code relating to the issuance of salvage certificates and the determination of a vehicle as a total loss. Upon not less than five days' notice and a hearing, the Commissioner may upon reasonable grounds cancel a certificate of self-insurance. Failure to pay any judgment within 30 days after such judgment has become final will constitute a reasonable ground for the cancellation of a certificate of self-insurance. (17D-6-2)

Certificate of Insurance - All insurance carriers transacting insurance in this state must give a certificate to the insured certifying that there is in effect a motor vehicle liability policy on that motor vehicle. The certificate must state its effective date and must describe all motor vehicles and replacement vehicles covered (unless the policy is issued to a person who is not the owner of a motor vehicle). Insurance companies must provide a certificate of insurance in duplicate for each policy term and for each vehicle included in a policy, except for those listed in a fleet policy. Each certificate must list the name of the policyholder and the name of the vehicle owner if different from the policyholder. The certificate or other proof of insurance must be carried by the insured in the appropriate vehicle for use as proof of security, and must be presented at the time of vehicle inspection. However, the insured will not be guilty of a violation if he or she furnishes proof that the insurance was in effect within seven days of being cited for not carrying the certificate or other proof in the vehicle. In this section, proof of insurance means a certificate of insurance, an insurance policy, a copy of an insurance policy, a certificate of self-insurance, or a copy of the current registration issued to a motor carrier by the Public Service Commission. No policy of motor vehicle liability insurance issued or delivered for issuance in this state may be contracted for a period of less than 90 days. (17D-2A-4, 5)

Investigation by Law-Enforcement - At the time of investigation of a motor vehicle offense or crash the State Police or other law-enforcement agency or when a vehicle is stopped by a law-enforcement officer for reasonable cause, the officer of the agency making the investigation may inquire of the operator of any motor vehicle involved and, by an inquiry through the on-line insurance verification program established by this Chapter as to the existence on the vehicle or vehicles of the evidence of insurance or other security and upon a finding by the law-enforcement agency, officer or agent that the security required is not in effect, he or she must notify the Division of Motor Vehicles of the finding within five days. The law-enforcement officer or agent may not stop vehicles solely to inquire as to the certificate of insurance. A defendant who is charged with a traffic offense that requires an appearance in court must present the court at the time of his or her appearance or subsequent appearance with proof that the defendant had security at the time of the traffic offenses subject to verification by the court through the Division of Motor Vehicles or its agent or by an on-line insurance verification program. If, as a result of the defendant's failure to show proof, the court determines that the defendant is in violation, the court will notify the Division of Motor Vehicles within five days. (17D-2A-6)

Suspension or Revocation of License and Registration - Any owner of a motor vehicle who fails to have the required security in effect at the time the vehicle is registered or being operated upon the roads or highways will have his or her driver's license suspended by the Commissioner of the Division of Motor Vehicles and have his or her motor vehicle registration revoked as follows:

- For the first offense, the Commissioner will suspend the driver's license for 30 days and until such time as he or she presents current proof of insurance on all currently registered vehicles. If, however, an owner complies and pays a penalty fee of $200 before the effective date of the suspension, the driver's license suspension of 30 days

and the vehicle registration revocation will not be imposed and no reinstatement fees are required.

- For the second or subsequent offense within five years, the Commissioner will suspend the owner's driver's license for a period of 90 days and revoke the owner's vehicle registration until he or she presents to the Division of Motor Vehicles the required proof of security.
- If the motor vehicle is titled and registered in more than one name, the Commissioner will suspend the driver's license of only one of the owners. (17D-2A-7)

Uninsured and Underinsured Motorist Coverage

No policy of bodily injury liability or property damage liability insurance (covering liability arising from the ownership, maintenance or use of any motor vehicle) may be issued or delivered in West Virginia to the vehicle owner, or issued by any insurer licensed in this state upon any motor vehicle for which a certificate of title has been issued by the Department of Motor Vehicles, unless it contains a provision insuring the named insured and any other person responsible for the use of the motor vehicle with the consent of the named insured or spouse against liability for death, bodily injury, loss or damage within the coverage of the policy as a result of negligence in the operation or use of the vehicle by the named insured or by such other person. This section does not include policies insuring a bailee for hire and any persons specifically excluded by any restrictive endorsement attached to a policy.

If coverage resulting from the use of a non-owned automobile depends on the consent of the vehicle owner, the word "owner" must include the custodian of non-owned motor vehicles. If the owner of a policy receives a notice of cancellation and the reason for the cancellation is a violation of law by a person insured under the policy, the owner may use a restrictive endorsement specifically excluding that person who violated the law. The restrictive endorsement will be effective for the total liability coverage provided under the policy, including coverage provided for the mandatory liability requirements. A policy must have an endorsement or provision undertaking to pay the insured all sums which he or she is legally entitled to recover as damages from the owner or operator of an uninsured motor vehicle, within limits which may be no less than the requirements of this section. The policy must provide an option to the insured (with appropriately adjusted premiums) to pay the insured all sums which he or she is legally entitled to recover as damages from the owner or operator of an uninsured motor vehicle up to $100,000 for bodily injury or death of one person in any one accident, and $300,000 for bodily injury or death of two or more persons in any one accident, and $50,000 for injury or destruction of property of others in any one accident.

The policy may have an endorsement or provisions to exclude the first $300 of property damage resulting from the negligence of an uninsured motorist. The policy must provide an option to the insured with appropriately adjusted premiums to pay the insured all sums he or she is legally be entitled to recover as damages from the owner or operator of an uninsured or underinsured motor vehicle up to an amount not less than limits of bodily injury liability insurance and property damage liability insurance purchased by the insured without setoff against the insured's policy or any other policy. (33-6-31)

Underinsured motor vehicle is a motor vehicle owned, operated, or used that is covered by liability insurance at the time of the accident, but the limits of that insurance are either less than limits the insured carried for underinsured motorists' coverage, or has been reduced by payments to others injured in the accident to limits less than limits the insured carried for underinsured motorists' coverage. No sums payable as a result of underinsured motorists' coverage may be reduced by payments made under the insured's policy or any other policy.

Named insured is the person named in the declarations of the policy, and also includes that person's spouse if a resident of the same household. The term insured means the named insured and, while resident of the same household, the spouse of the named insured and relatives of either, while in a motor vehicle or otherwise, and any person (except a bailee for hire) who has consent to use the motor vehicle by the named insured.

Uninsured motor vehicle is a motor vehicle for which:

- There is no bodily injury liability insurance and property damage liability insurance in the amounts specified by law;
- There is insurance but in amounts less than the state's minimums;
- There is insurance, but the insurance company writing the insurance denies coverage or is insolvent;
- There is a hit and run vehicle.

Hit and run motor vehicle is a motor vehicle causing damage to the insured's property because of physical contact with that motor vehicle, or which causes bodily injury to the insured because of physical contact with that motor vehicle with the insured or with a motor vehicle which the insured was occupying at the time of the accident. If the owner or operator of any motor vehicle causing bodily injury or property damage is unknown, an action may be instituted against the unknown defendant as "John Doe."

Underinsured Motor Vehicle is a motor vehicle for which the security in place meets the state's minimums, but that security is not enough to pay the liability claim.

Cancellation and Nonrenewal of an Automobile Policy

Permitted Reasons for Cancellation - An insurer having issued or delivered a policy providing automobile liability insurance insuring a private passenger automobile may (after the policy has been in effect for 60 days, or in case of renewal effective immediately) may not issue a notice of cancellation during the term of the policy except for one or more of the following reasons:

- The named insured fails to pay the premium when due or any installment;
- The policy was obtained through material misrepresentation;
- The insured violates any of the material terms and conditions of the policy;
- The named insured or any other operator (either resident in the same household or who customarily operates an automobile insured under the policy) has had a operator's license suspended or revoked during the policy period; or becomes

subject to epilepsy or heart attacks, and that person cannot produce a certificate from a physician testifying to his or her ability to operate a motor vehicle;

- Cancellation is also permitted under this section if the named insured or any other operator (either resident in the same household or who customarily operates an automobile insured under the policy) is convicted of or forfeits bail during the policy period for any of the following:
- Any felony or assault involving the use of a motor vehicle
- Negligent homicide arising out of the operation of a motor vehicle
- Operating a motor vehicle while under the influence of alcohol or any controlled substance
- Leaving the scene of a motor vehicle accident in which the insured is involved without reporting as required by law
- Theft or unlawful taking of a motor vehicle
- Making false statements in an application for a motor vehicle operator's license
- A third violation, committed within 12 months, of any misdemeanor moving traffic violation

No insurance company may cancel a policy of automobile liability insurance without first giving the insured 30 days notice by registered or certified mail of its intention to cancel. Cancellation of the policy by the insurer because the insured failed to pay the consideration upon initial issuance is effective after 10 days notice of cancellation to the insured. (33-6A-1)

Any cancellation by an insurer of a policy of automobile liability insurance which has been in effect for 60 days and which has been renewed will be void if that cancellation violates this section. (33-6A-2)

Notice of Cancellation to Loss Payee - A loss payee is defined as the person not a named insured designated on an automobile liability insurance policy contract as being entitled to the proceeds of or payments under the policy. In every instance in which an insurer notifies an insured of its intent to cancel or not renew an automobile liability insurance policy, the insurer must also provide notice to the loss payee of the cancellation and nonrenewal. (33-6A-1a)

Explanation of Reasons for Cancellation - When an automobile liability insurance policy that has been in effect for 60 days or that has been renewed is cancelled by the insurer, the insurer must specify the reason for the cancellation either in the notice of cancellation or at the written request of the named insured. The reasons must be stated in a written notice and must (if not provided in the notice) be made within 30 days after a request. However, there will be no liability on the part of, and no cause of action will arise against, any insurer, it's producers or it's authorized investigative sources for statements made in the required written notice. (33-6A-3)

Permitted Reasons for Nonrenewal - Insurers may not refuse to renew an outstanding automobile liability or physical damage insurance policy unless the named insured is given at least 45 days advance notice of the insurer's election not to renew the policy. This section will not prevent an insurer from refusing to issue an automobile liability or physical damage

insurance policy upon application, nor prevent an insurer from refusing to renew a policy upon expiration. Notice requirements must be followed, as well as the requirements for certain insureds to be submitted to the West Virginia assigned risk plan.

An insurer may not fail to renew an outstanding automobile liability or physical damage insurance policy which has been in existence for two consecutive years or longer, except for the reasons already specified as reasons for cancellation, with the following exceptions:

- Under the section discussing the conviction or forfeiture of bail during the policy period, the last item is changed to read "a second violation, committed within 12 months, of any moving traffic violation which constitutes a misdemeanor"
- This section for refusing to renew also adds the reason that the named insured or any other operator has had a second at-fault motor vehicle accident within 12 months

Nonrenewal of a policy for any reason is subject to hearing and review procedures. The cost of the hearing is assessed against the losing party, but will not exceed $75.

The insurer must renew any automobile liability or physical damage insurance policy that has not been renewed due to the insured's failure to pay the renewal premium when due, if none of the other grounds for nonrenewal exist and the insured makes application for renewal within 90 days of the original expiration date of the policy. If a policy is renewed, the coverage will not be retroactive to the original expiration date of the policy, but will resume upon the renewal date at the current premium levels offered by the company. (33-6A-4)

West Virginia "Automobile Insurance Plan" (Assigned Risk)

Substandard risk is an applicant for insurance who presents a greater exposure to loss than that contemplated by commonly used rate classifications, as evidenced by one or more of the following conditions:

- Record of traffic accidents;
- Record of traffic law violations;
- Undesirable occupational circumstances;
- Any other valid underwriting consideration.

Substandard risk rate is a rate or premium charge that reflects the greater than nominal exposure to loss which is assumed by an insurer writing insurance for a substandard risk.

Every application for a motor vehicle insurance policy and every policy to be issued in this state and written on the basis of a substandard risk rate schedule must have a printed statement in bold-faced type in a contrasting color, as follows:

THE POLICY FOR WHICH YOU ARE APPLYING HAS BEEN RATED IN ACCORDANCE WITH A SPECIAL RATING SCHEDULE FILED WITH THE COMMISSIONER OF INSURANCE PROVIDING FOR HIGHER PREMIUM CHARGES THAN THOSE GENERALLY APPLICABLE FOR AVERAGE RISKS. IF THE COVERAGE OR PREMIUM IS NOT

SATISFACTORY, YOU MAY BE ELIGIBLE FOR OTHER INSURANCE. IF THIS COVERAGE OR PREMIUM IS SATISFACTORY, YOU MAY BE ELIGIBLE FOR COVERAGE UNDER A STANDARD OR PREFERRED POLICY IF DURING THE NEXT THREE YEARS YOU HAVE NO TRAFFIC VIOLATIONS OR ACCIDENTS AND YOU MAINTAIN CONTINUOUS INSURANCE COVERAGE.

After July 1, 1995, all insurers selling or which have in force substandard risk motor vehicle insurance policies must provide a one time notice in writing to those policyholders who have maintained continuous insurance coverage for three years, have not been convicted of any moving traffic violations and had no at fault accidents, that they may be eligible for coverage under a standard or preferred policy. (114-37-3)

The Commissioner makes rules for the format, style, design and approval of substandard risk insurance applications, notices, policies and other procedures as required by this section. (33-6-31c)

The notice required in this section must be provided either by personal delivery or by regular mail addressed to the policyholder at the last address appearing for the policyholder in the records of the insurer. (114-37-7)

West Virginia Insurance Guaranty Association Act

This section of the Insurance Code may be cited as the "West Virginia Insurance Guaranty Association Act."

Purpose

The purpose of this Act is to provide a mechanism for the payment of covered claims under certain insurance policies to avoid excessive delay in payment and to avoid financial loss to claimants or policyholders because of the insolvency of an insurer, to assist in the detection and prevention of insurer insolvencies, and to provide an association to assess the cost of such protection among insurers. This Act applies to all kinds of direct insurance, ***except*** life, title, surety, disability, credit, mortgage guaranty and ocean marine insurance.

Definitions

"Account" means any one of the three accounts created by this Act.

"Association" means the West Virginia Insurance Guaranty Association created under this Act.

"Commissioner" means the Insurance Commissioner of West Virginia.

"Covered claim" means an unpaid claim, including one for unearned premiums other than retrospective premiums or other premiums subject to adjustment after the date of liquidation, which arises out of and is within the coverage of an insurance policy to which this Act applies and which policy is in force at the time of the occurrence giving rise to the unpaid claims if the insurer issuing the policy becomes an insolvent insurer after the effective date of this Act and

the claimant or insured is a resident of this state at the time of the insured occurrence, or the property from which the claim arises is permanently located in this state. "Covered claim" does not include:

- Any amount in excess of the applicable limits of coverage provided by an insurance policy to which this Act applies; nor
- any amount due any reinsurer, insurer, insurance pool, or underwriting association, as subrogation recoveries or otherwise from an insolvent insurer or the insured of an insolvent insurer to the extent of coverage under the insured's policy.

"Insolvent insurer" means an insurer:

- Licensed to transact insurance in this state either at the time the policy was issued or when the insured event occurred; and
- Against whom an order of liquidation with a finding of insolvency has been entered by a court of competent jurisdiction in the insurer's state of domicile or of this state.

"Member insurer" means any person who:

- Writes any kind of insurance to which this Act applies, including farmers' mutual fire insurance companies and the exchange of reciprocal or interinsurance contracts; and
- Is licensed to transact insurance in this state.

"Net direct written premiums" means direct gross premiums written in this state on insurance policies to which this Act applies, less return premiums on the policies and dividends paid or credited to policyholders on such direct business. "Net direct written premiums" does not include premiums on contracts between insurers or reinsurers.

"Person" includes an individual, company, insurer, association, organization, society, reciprocal, partnership, syndicate, business trust, corporation or any other legal entity.

"Receiver" means receiver, liquidator, rehabilitator or conservator as the context may require.

Creation of the Association

There has been created a nonprofit unincorporated legal entity to be known as the West Virginia Insurance Guaranty Association. All insurers defined as member insurers in this Act ***must be and remain members of the Association*** as a condition of their authority to transact insurance in this state. The Association will perform its functions under a plan of operation established and approved under this Act and will exercise its powers through a Board of Directors established under this Act. For purposes of administration and assessment, the Association has established and will maintain three separate accounts:

- The automobile insurance account;
- The workers' compensation insurance account; and
- The account for all other insurance to which this Act applies.

Board of Directors

The Board of Directors of the Association will consist of not less than five or more than nine persons serving terms as established in the plan of operation. The members of the Board will be selected by member insurers subject to the approval of the Commissioner. Vacancies on the Board will be filled for the remaining period of the term in the same manner as initial appointments. If no members are selected within 60 days after the effective date of this Act, the Commissioner may appoint the initial members of the Board of Directors. In approving selections to the Board, the Commissioner will consider among other things whether all member insurers are fairly represented. 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.

Powers and Duties of the Association

The Association is obligated to the extent of the covered claims existing prior to the determination of insolvency, and for those claims arising within 30 days after the determination of insolvency, but the obligation only includes that amount of each covered claim which is ***in excess of $100.00 and is less than $300,000***. However, neither of these monetary limits applies to obligations arising out of covered workers' compensation claims. In no event is the Association obligated to a policyholder or claimant in an amount in excess of the obligations of the insolvent insurer under the policy from which the claim arises. Notwithstanding any other provision of this Act, a covered claim does not include any claim filed with the Guaranty Fund after the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer. A default judgment or stipulated judgment against the insolvent insurer, or against the insured of an insolvent insurer, is not binding against the Association.

The Association is the insurer to the extent of its obligation on the covered claims and to such extent has all rights, duties, defenses and obligations of the insolvent insurer as if the insurer had not become insolvent.

The Association will allocate claims paid and expenses incurred among the three accounts separately, and assess member insurers separately for each account amounts necessary to pay the obligations of the Association subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, the cost of examinations and other expenses authorized by this Act. The assessments of each member insurer will be in the proportion that the net direct written premiums of the member insurer for the preceding calendar year on the kinds of insurance in the account bears to the net direct written premiums of all member insurers for the preceding calendar year on the kinds of insurance in the account; provided that farmers mutual insurance companies that do not issue workers' compensation insurance policies may not be assessed to pay for the obligations of the Association payable from the workers' compensation insurance account. Each member insurer will be notified of the assessment not later than 30 days before it is due. No member insurer may be assessed in any one year on any account an amount greater than 2% of that member insurer's net direct written premiums for the preceding calendar year on the kinds of insurance in the account. If the maximum assessment, together with the other assets of the Association in any account,

does not provide in any one year in any account an amount sufficient to make all necessary payments from that account, the funds available will be prorated and the unpaid portion will be paid as soon after that as funds become available.

The Association may exempt or defer, in whole or in part, the assessment of any member insurer, if the assessment would cause the member insurer's financial statement to reflect the amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance. Each member insurer may set off against any assessment, authorized payments made on covered claims and expenses incurred in the payment of such claims by the member insurer if they are chargeable to the account for which the assessment is made.

The Association will investigate claims brought against the Association and adjust, compromise, settle, and pay covered claims to the extent of the Association's obligation and deny all other claims and may review settlements, releases and judgments to which the insolvent insurer or its insureds were parties to determine the extent to which the settlements, releases and judgments may be properly contested.

As directed by the Commissioner, the Association will notify the insureds of the insolvent insurer and any other interested parties of the determination of insolvency and of their rights under this Act.

The Association will handle claims through its employees or through one or more insurers or other persons designated as servicing facilities. Designation of a servicing facility is subject to the approval of the Commissioner, but the designation may be declined by a member insurer.

The Association will reimburse each servicing facility for obligations of the Association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the Association and will pay the other expenses of the Association authorized by this Act.

The Association may:

- Employ or retain persons that are necessary to handle claims and perform other duties of the Association.
- Borrow funds necessary to effect the purposes of this Act in accord with the plan of operation.
- Sue or be sued.
- Negotiate and become a party to contracts that are necessary to carry out the purpose of this Act.
- Perform other acts that are necessary or proper to effectuate the purpose of this Act.
- Refund to the member insurers in proportion to the contribution of each member insurer to an account that amount by which the assets of the account exceed the liabilities, if, at the end of any calendar year, the Board of Directors finds that the assets of the Association in any account exceed the liabilities of that account as estimated by the Board of Directors for the coming year.

Plan of Operation

The Association must:

- 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 will become effective upon approval in writing by the Commissioner.
- If the Association fails to submit a suitable plan of operation within 90 days following the effective date of this Act or if at any time thereafter the Association fails to submit suitable amendments to the plan, the Commissioner will, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this Act. Such rules will continue in force until modified by the Commissioner or superseded by a plan submitted by the Association and approved by the Commissioner. All such rules must be promulgated in accordance with the provisions of the Insurance Code.

All member insurers must comply with the plan of operation. The plan of operation will:

- Establish the procedures whereby all the powers and duties of the Association will be performed.
- Establish procedures for handling assets of the Association.
- Establish the amount and method of reimbursing members of the Board of Directors under this Act.
- Establish procedures by which claims may be filed with the Association and establish acceptable forms of proof of covered claims. Notice of claims to the receiver of the insolvent insurer will be deemed notice to the Association or its agent and a list of such claims must be periodically submitted to the Association or similar organization in another state by the receiver.
- Establish regular places and times for meetings of the Board of Directors.
- Establish procedures for records to be kept of all financial transactions of the Association, its agents, and the Board of Directors.
- Provide that any member insurer aggrieved by a final action or decision of the Association may appeal to the Commissioner within 30 days after the action or decision.
- Establish the procedures whereby selections for the Board of Directors will be submitted to the Commissioner.
- Contain additional provisions necessary or proper for the execution of the powers and duties of the Association.

The plan of operation may provide that any or all powers and duties of the Association 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 will be reimbursed as a servicing facility would be reimbursed and will be paid for its performance of any other functions of the Association. A delegation under this section will 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 Act.

Duties and Powers of the Commissioner

The Commissioner must:

- Notify the Association of the existence of an insolvent insurer not later than three days after he receives notice of the determination of the insolvency.
- Upon request of the Board of Directors, provide the Association a statement of the net direct written premiums of each member insurer.

The Commissioner may:

- Require that the Association notify the insureds of the insolvent insurer and any other interested parties of the determination of insolvency and of their rights under this Act. Such notification will be by mail at their last known address, where available, but if sufficient information for notification by mail is not available, notice by publication in a newspaper of general circulation will be sufficient.
- 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 fine on any member insurer which fails to pay an assessment when due. Such fine will not exceed 5% of the unpaid assessment per month, except that no fine will be less than $100.00 per month.
- Revoke the designation of any servicing facility if he finds claims are being handled unsatisfactorily.

Any final order of the Commissioner under this Act will be subject to judicial review as provided by this Chapter.

Effect of Paid Claims

Any person recovering under this Act will be deemed to have assigned his rights under the policy to the Association to the extent of his recovery from the Association. Every insured or claimant seeking the protection of this Act must cooperate with the Association to the same extent as such person would have been required to cooperate with the insolvent insurer. The Association will have no cause of action against the insured of the insolvent insurer for any sums it has paid out except such causes of action as the insolvent insurer would have had if such sums had been paid by the insolvent insurer. In the case of an insolvent insurer operating on a plan whereby insurance policies with assessment liability have been issued to insureds, payments of claims by the Association will not operate to reduce the liability of such insureds to the receiver for unpaid assessments.

The receiver of an insolvent insurer will be bound by settlements of covered claims by the Association or a similar organization in another state, subject to the approval of the court having jurisdiction of the receivership. The court having jurisdiction will grant such claims priority equal to that to which the claimant would have been entitled, in the absence of this Act, against the assets of the insolvent insurer. The expenses of the Association or similar organization in handling claims will be accorded the same priority as the receiver's expenses.

The Association will periodically file with the receiver of the insolvent insurer statements of the covered claims paid by the Association and estimates of anticipated claims against the Association which will preserve the rights of the Association against the assets of the insolvent insurer.

Non-Duplication of Recovery

Any person having a claim against a solvent insurer under any provision in an insurance policy other than a policy of an insolvent insurer, which is also a covered claim, is required to exhaust first his or her right under the solvent insurer's policy. Any amount payable on a covered claim under this Act will be reduced by the amount of any recovery under the solvent insurer's policy.

Any person having a claim which may be recovered under more than one Insurance Guaranty Association or its equivalent must seek recovery first from the Association of the place of residence of the insured except that if it is a first party claim for damage to property with a permanent location, he or she must seek recovery first from the Association of the location of the property, and if it is a workers' compensation claim, the person must seek recovery first from the Association of the residence of the claimant. Any recovery under this Act will be reduced by the amount of the recovery from any other insurance guaranty association or its equivalent.

Prevention of Insolvencies

To aid in the detection and prevention of insurer insolvencies:

- It will be the duty of the Board of Directors, upon majority vote, to notify the Commissioner of any information indicating that any member insurer may be insolvent or in a financial condition hazardous to the policyholders or the public.
- 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 in a financial condition hazardous to the policyholders or the public. Within 30 days of the receipt of such request, the Commissioner will begin the 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 such examination will be paid by the Association and the examination report will be treated as are other examination reports. In no event will such examination report be released to the Board of Directors prior to its release to the public. The Commissioner

will notify the Board of Directors when the examination is completed. The request for an examination will be kept on file by the Commissioner but it will not be open to public inspection prior to the release of the examination report to the public.

- It will be the duty of the Commissioner to report to the Board of Directors when he has reasonable cause to believe that any member insurer examined or being examined at the request of the Board of Directors may be insolvent or in a financial condition hazardous to the policyholders or the public.
- 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. Such reports and recommendations will not be considered public documents.
- The Board of Directors may, upon majority vote, make recommendations to the Commissioner for the detection and prevention of insurer insolvencies.
- The Board of Directors will, at the conclusion of any insurer insolvency in which the Association was obligated to pay covered claims, prepare a report on the history and causes of such insolvency, based on the information available to the Association, and submit such report to the Commissioner.

Examination of Association

The Association will be subject to examination and regulation by the Commissioner. The Board of Directors must submit, not later than March 30th of each year, a financial report for the preceding calendar year, in a form approved by the Commissioner.

Tax Exemption

The Association will be exempt from payment of all fees and all taxes levied by this state or any of its subdivisions except taxes levied on real or personal property.

Recognition of Assessments in Rates

The rates and premiums charged for insurance policies to which this Act applies will include amounts sufficient to recoup a sum equal to the amounts paid to the Association by the member insurer less any amounts returned to the member insurer by the Association and such rates will not be deemed excessive because they contain an amount reasonably calculated to recoup assessments paid by the member insurer.

Immunity

There will be no liability on the part of and no cause of action of any nature will arise against any member insurer, the Association or its agents or employees, the Board of Directors, or the Commissioner or his representatives for any action taken by them in the exercise and performance of their powers and duties under this Act.

Stay of Proceedings

All proceedings in which the insolvent insurer is a party or obligated to defend a party in any court in this state will be stayed for six months from the date the proof of claim provided for in this Chapter is filed with the receiver to permit proper defense by the Association of all pending causes of action. As to any covered claims arising from a judgment under any order, decision, verdict or finding based on the default of the insolvent insurer or its wrongful failure to defend an insured, the Association either on its own behalf or on behalf of such insured may apply to have such judgment, order, decision, verdict or finding set aside by the same court or administrator that made such judgment, order, decision, verdict or finding and will be permitted to defend against such claim on the merits.

Severability

In the event any part or provision of this Act be held to be unconstitutional by any court of competent jurisdiction, such holding and decision of the court will not affect the validity and constitutionality of the remaining parts and provisions of this Act. (33-26-1 – 19)

Mine Subsidence Insurance

Mine subsidence in West Virginia has resulted in great loss of home, shelter and property to the citizens of this state to the detriment of the health, safety and welfare of such citizens. The state has declared that programs to alleviate these problems constitute the carrying out a needed public purpose. (33-30-1)

This law is intended to make mine subsidence insurance available in a reasonable and equitable manner to all residents of West Virginia through the office of the State Board of Risk and Insurance Management. (33-30-2)

Definitions

Mine Subsidence - loss to a structure caused by lateral or vertical movement (including a resulting collapse) of structures from collapse of man-made underground coal mines. It does not include loss caused by earthquake, landslide, volcanic eruption or collapse of storm and sewer drains and rapid transit tunnels.
Structure - any dwelling, building or fixture permanently affixed to realty located in West Virginia, including basements, footings, foundations, septic systems and underground pipes directly servicing the dwelling or building. Structure does not include driveways, sidewalks, parking lots, land, trees, plants, crops or agricultural field drainage tile. (33-30-3)

Mine Subsidence Insurance Fund - There is hereby established within the office of the state Board of Risk and Insurance Management a fund to be known as the "Mine Subsidence Insurance Fund." The Board must operate the Fund pursuant to this article.

The Fund must make available insurance coverage against losses arising out of or due to mine subsidence within this state as to any structure within this state. The moneys in the Fund will be derived from premiums for subsidence insurance collected on behalf of the Board pursuant to this article. The Board will be empowered to invest the Fund and first use the interest there from for claim payments and administration expenses.

Premiums for subsidence insurance will be established by the Board, which will periodically review the premium level and the experience data applicable to operation of the Fund and make changes as required.

Premiums must be established at a rate or within a schedule of rates sufficient to satisfy all foreseeable claims upon the Fund during the period of coverage, giving due consideration to relevant loss or claim experience or trends, to cover normal costs of operation of the Fund by the Board and provide a reasonable reserve fund for unexpected contingencies. Deviation from the premium set by the Board will not be allowed. (33-30-4)

Mine Subsidence Coverage

Every insurance policy issued or renewed insuring on a direct basis a structure located in West Virginia must include, at a separately stated premium, insurance for loss caused by mine subsidence, unless waived by the insured. However, no waiver will be required and coverage will only be provided if requested by the insured in the following counties: Berkeley, Cabell, Calhoun, Hampshire, Hardy, Jackson, Jefferson, Monroe, Morgan, Pendleton, Pleasants, Ritchie, Roane, Wirt, and Wood. The premium charged for coverage is set by the Board.

The loss coverage is the loss in excess of 2% of the policy's total insured value, ***but at no time will the deductible be less than $250 nor more than $500.*** The total insured value reinsured by the Board ***may not exceed $75,000.*** Also, the amount of mine subsidence reinsurance must not exceed the amount of the fire insurance on the structure. (33-30-6)

Premiums for mine subsidence coverage are to be collected by insurers writing the coverage on their policies, and is to be placed into the "Mine Subsidence Insurance Fund." The Fund is used by the Board for claim payments and administrative expenses. (33-30-4)

If monies in the Fund are insufficient to pay claims, reserves, or unexpected contingencies, the legislature may appropriate amounts to the Fund, or the governor may grant to the Fund monies from the civil contingency fund. (33-30-5)

Mine subsidence coverage may be refused on a structure with unrepaired subsidence damage until necessary repairs are made. Coverage may also be refused where the insurer has declined, non-renewed, or cancelled a policy for underwriting reasons unrelated to mine subsidence. Lastly, coverage may be declined on a structure which has loss or damage in progress. Disputes which may arise are subject to hearings and appeal provisions. (33-30-7)

Reinsurance Agreements

All companies authorized to write fire insurance in West Virginia must enter into a reinsurance agreement with the Board in which each insurer agrees to cede to the Board 100% (up to $75,000), of any subsidence insurance coverage issued. In consideration of the ceding commission retained by the insurer, the insurer must agree to absorb all expenses of the insurer necessary for sale of policies and any administration duties of the mine subsidence insurance program imposed upon it under the terms of the reinsurance agreement.
The Board is authorized to undertake adjustment of losses and administer the Fund, or it may provide in a reinsurance agreement that the insurer do so. The Board must agree to reimburse the insurer from the Fund for all amounts paid policyholders for claims resulting from mine subsidence and pay from the Fund all costs of administration incurred by the Board. An insurer is not required to pay any claim for any loss insured under this section except to the extent that the amount available in the Mine Subsidence Insurance Fund is sufficient to reimburse the insurer for the claim under this section. (33-30-8)

Payment of Claims

Under the reinsurance agreements authorized by this section, the Board must pay the insurer all amounts due out of the Fund, within 90 days after receiving the loss report. ***All claims of insureds must be paid within 120 days after proof of loss is presented to an insurer, unless otherwise agreed by the insurer and claimant.*** Upon payment of the claim of an insured from the Fund, the insured is deemed to have waived any cause of action for damages caused by subsidence to the extent of the payment from the Fund. (33-30-10)

Each insurer issuing mine subsidence insurance policies in this state has the right of subrogation. The Board may exercise the right of subrogation. (33-30-13)

The West Virginia Risk Retention Act

The Risk Retention Act of West Virginia regulates the formation and operation of risk retention groups and purchasing groups in this state formed under the provisions of the federal liability risk retention act of 1986. (33-32-1)

Definitions

Risk Retention Group - any corporation or other limited liability association formed under the laws of any state whose primary activity consists of assuming and spreading the liability exposure of its group members. The group must be chartered and licensed as a liability insurance company and authorized to engage in the business of insurance. No person may be excluded from membership in the group solely to provide members of the group a competitive advantage over that person. Members must be engaged in businesses or activities with similar or liability exposures by virtue of any related, similar, or common business trade, product, services, premises or operations. The group's activities must not include the provision of insurance other than:

- Liability insurance for assuming and spreading all or any portion of the liability of its group members;
- Reinsurance with respect to the liability of any other risk retention group or any members of such other group which is engaged in businesses or activities so that such group or member meets the reinsurance requirements.

The name of the group must also include the phrase "Risk Retention Group."

Purchasing Group - any group which has as one of its purposes the purchase of liability insurance on a group basis; purchases such insurance only for its group members and only to cover their similar or related liability exposures; is composed of members whose businesses or activities have similar liability exposures by virtue of any related, similar, or common business, trade, product, services, premises or operations; and is domiciled in any state. (33-32-2)

Duty on Agents or Brokers to Obtain License

A person, or a person working for a firm, association or corporation, may not act or aid in any manner in soliciting, negotiating or procuring liability insurance in this state from a risk retention group or for a purchasing group from an authorized insurer or a risk retention group chartered in a state unless such person is licensed as an insurance agent in accordance with this Chapter.

A person, or a person working for a firm, association or corporation, may not act or aid in any manner in soliciting, negotiating or procuring liability insurance from an insurer not authorized to do business in this state on behalf of a purchasing group located in this state unless such person, or person working for a firm, association or corporation, is licensed as an excess line broker in accordance with this Chapter.

For purposes of acting as an agent for a risk retention group or purchasing group pursuant to the provisions of this section, the requirement of residence in this state does not apply.

Every person, or person working for a firm, association or corporation, licensed pursuant to the provisions of this Chapter, on business placed with risk retention groups or written through a purchasing group, must inform each prospective insured or purchasing group of the provisions of the following notices required by this article. (33-32-21)

Notice to Purchasers - Every application form for insurance from a risk retention group and any policy issued by a risk retention group must contain in ten-point type on the front page and the declaration page, the following notice: "Notice: This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and rules of your state. State insurance insolvency guaranty funds are not available for your risk retention group." (33-32-9)

Restrictions on Insurance Purchased by Purchasing Groups - A purchasing group which obtains liability insurance from an insurer not admitted in this state or a risk retention group must inform each of the members of the group which has a risk resident or located in this state

that the risk is not protected by an insurance insolvency guaranty fund in this state, and that the risk retention group or insurer may not be subject to all insurance laws and regulations of this state. To give notice as required by this section, the purchasing group must ensure that each group certificate or evidence of insurance has printed or stamped in contrasting color on the front page the following statement: "This insurer is not licensed to do business in West Virginia, and is not subject to the West Virginia insurance guaranty act or to all of the protections of the insurance laws and rules of this state." (33-32-18)

Malpractice Policies

Grounds for Cancellation

This section applies to malpractice insurance policies which have been in effect for at least 60 days or have been renewed at least once. (33-20C-1)

No insurer once having issued or delivered a policy providing malpractice insurance in West Virginia may cancel that policy, except for one or more of the following reasons:

- The named insured fails to discharge any of his or her obligations to pay premiums for the policy or any installment within a reasonable time of the due date
- The policy was obtained through material misrepresentation
- The insured violates any of the material terms and conditions of the policy
- The unavailability of reinsurance, upon sufficient proof being supplied to the Commissioner

Any purported cancellation of a policy providing malpractice insurance attempted in violation of this section will be void. (33-20C-2)

Notice of Cancellation

Where a policy or contract of malpractice insurance is cancelled by the insurer, the insurer or an authorized producer must cite within the written notice the allowable reason in this section for canceling the policy, and specifically state the circumstances giving rise to the allowable reason. The notice must further state that the insured has a right to request a hearing within 30 days. (33-20C-3)

Notice Period

No insurer may refuse to renew a policy or contract providing malpractice insurance unless written notice of the nonrenewal is forwarded to the insured by certified mail, return receipt requested, not less than 90 days before the policy expiration date. No insurer may cancel a policy or contract providing malpractice insurance during the term of the policy unless written notice of cancellation is forwarded to the insured by certified mail, return receipt requested, not more than 30 days after the reason for cancellation arose or occurred or the insurer

learned that it arose or occurred and not less than 30 days before the effective cancellation date. (33-20C-4)

Hearing & Review

Any insured aggrieved by the cancellation of a policy or contract providing malpractice insurance may request a hearing before the Commissioner within 30 days of the receipt of any such notice. The policy will remain in effect until Commissioner's order is entered. Any party aggrieved by an order of the Commissioner may seek judicial review in the circuit court. (33-20C-5)

Homeowner & Dwelling Policy Regulations

Declinations, Cancellations & Refusals to Renew

The purpose of this section is to regulate declinations, cancellations and refusals to renew certain policies of property insurance and to provide for disclosure of the reasons for these actions. (33-17A-1)

This article applies to policies of property insurance (other than policies of inland marine insurance and property insurance issued through a residual market mechanism) covering risks to property located in West Virginia which insure any of the following contingencies:

- Loss of or damage to real property which is used predominantly for the residential purposes of the named insured and which consists of not more than four dwelling units
- Loss of or damage to personal property in which the named insured has an insurable interest where the personal property is used for personal, family or household purposes; and the personal property is within a residential dwelling (33-17A-2)

Definitions

Declination - the refusal of an insurer to issue a property insurance policy on a written application or written request for coverage. The offer of insurance coverage with a company within an insurance group which is different from the company requested on the application or the offer of insurance upon different terms than requested in the application is not considered a declination if the offer is based upon any valid underwriting reason which involves a substantial increase in the risk.

Nonpayment of Premium - the failure of the named insured to discharge any obligation in connection with the payment of premiums on policies of property insurance, whether the payments are payable to the insurer or its producer or payable under a premium finance plan or extension of credit. Nonpayment of premium includes the failure to pay dues or fees where payment of dues or fees is a prerequisite to obtaining or continuing property insurance coverage.

Renewal - means the issuance and delivery by an insurer at the end of a policy period of a policy superseding a policy previously issued and delivered by the same insurer. Renewal includes the issuance and delivery of a certificate or notice extending the term of an existing policy beyond its policy period or term. Any policy period or term of less than six months is considered a policy period or term of six months, and any policy period or term of more than one year or any policy with no fixed expiration date is considered a policy period or term of one year.

Termination - either a cancellation or nonrenewal of property insurance coverage in whole or in part. A cancellation occurs during the policy term. A nonrenewal occurs at the end of the policy term. The transfer of a policyholder between companies within the same insurance group is not considered a termination, if the transfer is based upon any valid underwriting reason which involves a substantial increase in the risk. Each company or group of companies instituting a transfer must give notice to the insured as to the reasons for the transfer. Requiring a reasonable deductible, reasonable changes in the amount of insurance, or reasonable reductions in policy limits or coverage is not considered a termination if the requirements are directly related to the hazard involved and are made on the renewal date of the policy. (33-17A-3)

Policy Cancellation and Refusal to Insure

Upon declining to insure any real or personal property, the insurer must provide the applicant with a written explanation of the specific reasons at the time of the declination. The provision of an insurance application form by an insurer does not create a right to coverage on the behalf of the insured to which the insured is not otherwise entitled.

A notice of cancellation of property insurance coverage by an insurer must be in writing, delivered to the named insured or sent by first class mail to the named insured at the insured's last known address. The notice must state the effective date of the cancellation and give a written explanation of the specific reasons for the cancellation.

At least 30 days before the end of a policy period, an insurer must deliver or send by first class mail a notice of its intention regarding the renewal of the property insurance policy. Notice of an intention not to renew a property insurance policy must give an explanation of the specific reasons for the nonrenewal. However, no insurer may fail to renew an outstanding property insurance policy which has been in existence for four years or longer except for the reasons listed in the section on reasons for cancellation, or for other valid underwriting reasons which involve a substantial increase in the risk. (33-17A-4)

Reasons for Cancellation

After coverage has been in effect for more than 60 days or after the effective date of a renewal policy, a notice of cancellation may not be issued unless it is based on at least one of the following reasons:

- Nonpayment of premium;

- Conviction of the insured of any crime having as one of its necessary elements an act increasing any hazard insured against;
- Discovery of fraud or material misrepresentation made by or with the knowledge of the named insured in obtaining the policy, continuing the policy or in presenting a claim;
- Discovery of willful or reckless acts or omissions on the part of the named insured which increase any hazard insured against;
- The occurrence of a change in the risk which substantially increases any hazard insured against after insurance coverage has been issued or renewed;
- A violation of any local fire, health, safety, building or construction regulation or ordinance with respect to any insured property or the occupancy which substantially increases any hazard insured against;
- A determination by the Commissioner that the continuation of the policy would place the insurer in violation of the insurance laws of this state;
- Real property taxes owing on the insured property have been delinquent for two or more years and continue delinquent at the time notice of cancellation is issued;
- The insurer which issues the policy ceases writing the particular type or line of insurance coverage contained in the policy throughout the state or the insurer discontinues operations within the state;
- Substantial breach of the policy provisions. (33-17A-5)

Prohibited Discriminatory Practices

No insurer may decline to issue or terminate a policy or insurance subject to this article if the declination or termination is:

- Based upon the race, religion, nationality, ethnic group, age, sex or marital status of the applicant or named insured;
- Based solely upon the lawful occupation or profession of the applicant or named insured, unless such decision is for a business purpose which is not a mere pretext for unfair discrimination (However, this provision will not apply to any insurer, producer or broker which limits its market to one lawful occupation or profession or to several related lawful occupations or professions.);
- Based upon the age or location of the residence of the applicant or name insured, unless the decision is for a business purpose which is not a mere pretext for unfair discrimination or unless the age or location materially affects the risk;
- Based upon the fact that another insurer previously declined to insure the applicant or terminated an existing policy in which the applicant was the named insured;
- Based upon the fact that the applicant or named insured previously obtained insurance coverage through a residual market insurance mechanism;
- Based upon the fact that the applicant has not previously been insured;
- Based upon the fact that the applicant did not have insurance coverage for a period of time prior to the application.
- Based solely upon an adverse credit report or adverse credit rating. (33-17A-6)

West Virginia Workers Compensation

Workers compensation insurance is a form of casualty insurance providing all compensation and benefits required by the West Virginia Code. (33-1-10(e)(14))

Employers Subject to Workers Compensation

The following are considered employers within the meaning of this Chapter and are required to provide workers compensation coverage for the protection of their employees and are subject to all requirements of this Chapter and all rules prescribed by the state of West Virginia.

- The State of West Virginia and all governmental agencies or departments created by it, including county boards of education, political subdivisions of the state;
- Any volunteer fire department or company and other emergency service organizations; and
- All persons, firms, associations and corporations regularly employing another person or persons for the purpose of carrying on any form of industry, service or business in this state.

The following employers are not required to subscribe to the Fund, but ***may elect*** to do so:

- Employers of employees in domestic services;
- Employers of five or fewer full-time employees in agricultural service;
- Casual employers - An employer is a casual employer when the number of his or her employees does not exceed three and the period of employment is temporary, intermittent and sporadic in nature and does not exceed 10 calendar days in any calendar quarter;
- Churches;
- Employers engaged in organized professional sports activities, including employers of trainers and jockeys engaged in thoroughbred horse racing;
- Any volunteer rescue squad or volunteer police auxiliary unit organized under the auspices of a county commission, municipality or other government entity or political subdivision; volunteer organizations created or sponsored by government entities, political subdivisions; or area or regional emergency medical services boards of directors in furtherance of the purposes of the Emergency Medical Services Act of West Virginia; or
- Any employer whose employees are eligible to receive benefits under the federal Longshore and Harbor Workers Compensation Act.

Notwithstanding any other provision of this Chapter to the contrary, whenever there are churches in a circuit which employ one individual clergyman and the payments to the clergyman from the churches constitute his or her full salary, such circuit or group of churches may elect to be considered a single employer for the purpose workers compensation insurance.

Employers who are not required to workers compensation coverage may voluntarily choose to do so.

Any foreign corporation employer whose employment in this state is to be for a definite or limited period which could not be considered "regularly employing" within the meaning of this section may choose to purchase workers compensation coverage, and at the time of making application, the employer must furnish a statement under oath showing the probable length of time the employment will continue in this state, the character of the work, an estimate of the monthly payroll and any other information which may be required by the insurer.

"Regularly employing" or "regular employment" means employment by an employer which is not a casual employer under this section. (23-2-1(a)(b)(i))

Review Quiz

1. In the insurance mechanism:

   I. A large, uncertain loss is exchanged for a small known cost.
   II. The insured transfers the risk of loss to the insurer.
   III. The insured may retain part of the risk through deductibles.

   A. I only
   B. I and II
   C. II and III
   D. I, II, III

2. Insurance companies incorporated under the laws of foreign countries are:

   A. domestic companies
   B. foreign companies
   C. alien companies
   D. none of the above

3. Restoring an insured to the economic position enjoyed prior to a loss is a definition of:

   A. insurance
   B. insured
   C. uncertainty
   D. indemnification

4. Misrepresentation and concealment prevent recovery under an insurance contract if:

   I. Fraud is involved
   II. They are material to acceptance of the risk
   III. Insurer would have declined application had facts been known

   A. I only
   B. II only
   C. II and III
   D. I, II, and III

5. Which one of the following is considered to be misrepresentation and is illegal?

A. Circulating any oral, derogatory statement calculated to injure any person engaged in the business of insurance.
B. Issuing a true statement about the terms of a policy issued or to be issued.
C. Returning a portion of the premium to be insured on a basis not specified in the contract.
D. Issuing a statement which is not entirely true about the terms of a policy issued or to be issued.

6. Rebating is:

A. Issuing any statement which is not entirely true about the terms of a policy to be issued.
B. Committing any act that infringes on a purchaser's freedom to choose insurers.
C. Offering any special inducements of valuable consideration whatsoever, not specified in the contract.
D. Making untrue statements about a policyholder's present policy.

7. Which of the following terms means that the purchaser of insurance must be in a position to lose money or something of value if the contingency insured against should happen?

A. adhesion
B. insurable interest
C. personal aspect
D. executory

8. The state law requires that an applicant for an insurance producer's license must be at least:

A. 18 years of age
B. 21 years of age
C. 19 years of age
D. There is no age requirement

9. Rates and forms must be filed with and approved by the Commissioner at least ___ days before being used.

A. 30
B. 15
C. There is no set time.
D. 60

10. The penalty for a producer who overcharges or fails to return the premiums to persons so entitled may be:

A. a fine.
B. a license revocation.
C. a license suspension.
D. all of the above.

11. Good cause as grounds for refusal, revocation or suspension of an insurance license includes:

A. a material misstatement in the application for a license.
B. willful violation of the state insurance law.
C. fraudulent or dishonest practices.
D. all of the above.

12. State insurance laws generally state that insurance rates must be:

A. adequate enough to cover losses, administrative expenses, and provide a fair profit.
B. not excessive, the insurance company should not make an excessive profit.
C. non-discriminatory, rates should be applied fairly to all policyholders.
D. all of the above.

13. Producers found guilty of knowingly violating unfair trade practice regulations may be subject to a fine of up to ___ for each offense up to an aggregate of _____.

A. $500 / $5,000
B. $1,000 / $10,000
C. $2,500 / $25,000
D. $5,000 / $100,000

14. An insurance company incorporated under the laws of the state of Ohio, transacting business in West Virginia is considered what type of insurer in West Virginia?

A. Domestic Insurer.
B. Alien Insurer.
C. Foreign Insurer.
D. None of the above.

15. All of the following individuals are required to be licensee in West Virginia, except:

A. producers
B. surplus lines broker
C. regular salaried officer of an insurance company
D. solicitors

16. All of the following are unfair claims practices except:

A. denying a claim not covered under the policy.
B. not responding promptly when a claim is submitted.
C. forcing insured to sue by offering less than the claim is worth.
D. telling the insured that the company appeals arbitration awards.

17. If a producer unintentionally violates West Virginia insurance law, the Commissioner may impose a fine of _____ per offense up to an aggregate of _____ .

A. $500 / $5,000
B. $1,000 / $10,000
C. $2,500 / $25,000
D. $5,000 / $100,000

18. According to West Virginia's valued policy law, any fire policies insuring real property must offer the _____ of the insured in the event of a total loss.

A. full policy limits.
B. full market value.
C. actual cash value.
D. replacement cost.

19. An individual has an insurable interest in property when damage or destruction to that property results in:

A. loss
B. financial loss
C. hardship
D. diminished results

20. In property and casualty insurance, insurable interest must exist at the _____ in order for the insured to recover under the policy.

A. time of loss
B. time of settlement
C. time of purchase
D. all of the above

21. Binders are issued for a maximum period of _____ days in West Virginia unless extended by the Commissioner.

A. 30
B. 60
C. 90
D. 120

22. Binders do not apply to _____ insurance.

A. life
B. individual health
C. group health
D. any of the above

23. Insurance rates and forms must be filed with the Commissioner at least _____ days before being used. If not specifically rejected during this period, they are considered approved.

A. 30
B. 60
C. 90
D. 120

24. What are the qualifications for a West Virginia surplus lines license?

A. Applicant must hold a current property and casualty individual producer license.
B. Applicant must pay a $200 annual license fee.
C. Applicant must pass a qualifying examination.
D. All of the above.

25. Anyone having an insurable interest in real property and unable to obtain fire and extended coverage in the voluntary market can apply to the:

A. insurance guaranty association
B. fair plan
C. assigned risk plan
D. risk retention plan

26. West Virginia automobile settlements are governed by a _____ doctrine.

A. comparative negligence
B. contributory negligence
C. no-fault
D. personal injury

27. Effective January 1, 2016, the minimum limits of automobile liability coverage in West Virginia increased to:

A. $10/20/5
B. $15/30/5
C. $20/50/10
D. $25/50/25

28. Effective January 1, 2016, uninsured motorist coverage must be offered in West Virginia in the following minimum limits:

A. $10/20/5
B. $15/30/5
C. $20/40/10
D. $25/50/25

29. An auto policy may be canceled for any reason in West Virginia for the first ____days after issue:

A. 30
B. 60
C. 90
D. 120

30. A cancellation notice must be sent to an insured _____ days prior to the effective date unless the reason for cancellation of the auto policy is for non-payment of premium:

A. 10
B. 30
C. 45
D. 60

31. If an auto policy is being cancelled for non-payment of premium, _____ days notice must be given:

A. 10
B. 30
C. 45
D. 60

32. Non-renewal of an auto policy requires _____ days notice.

A. 10
B. 30
C. 45
D. 60

33. Once an auto policy has been in effect for 60 days in West Virginia, it can be cancelled for which of the following reasons pertaining to the insured?

A. non-payment of premium
B. auto insurance application fraud
C. motor vehicle homicide
D. all of the above

34. Individuals unable to obtain auto insurance in the voluntary market in West Virginia may apply to the:

A. joint underwriting association
B. West Virginia automobile insurance plan
C. guaranty association
D. surplus lines market

35. The West Virginia Property and Casualty Insurance Guaranty Association was established to protect the West Virginia insurance public from:

A. mine subsidence
B. unavailability of auto insurance
C. insurer insolvencies
D. unavailability of any property and casualty coverage

36. Mine subsidence insurance does not include loss caused by the following:

A. lateral movement to structures from collapse of a man-made underground mine.
B. vertical movement to structures from collapse of a man-made underground mine.
C. earthquake
D. all of the above

37. In West Virginia, the _____ administers the state-sponsored mine subsidence insurance:

A. Insurance Guaranty Association
B. Board of Risk Insurance Management
C. Assigned Risk Plan
D. Surplus Lines Plan

38. In West Virginia, the maximum amount of coverage per structure available for mine subsidence insurance is:

A. $25,000
B. $75,000
C. $200,000
D. $500,000

39. Insurable interest exists only when a number of conditions are met. Which of the following is not one of the requirements for insurable interest?

A. applicant must face a personal risk of loss.
B. applicant must have an interest in protecting what is insured.
C. applicant must not have a potential for gain because of the insurance.
D. applicant must not share the interest with anyone else.

40. Something that may increase the seriousness of a loss if a loss occurs, or that increases the likelihood that a loss will occur, is called a:

A. catastrophe
B. peril
C. risk
D. hazard

41. An insurance policy is a legal contract. Each of the following elements is necessary for the formation of a valid contract except:

A. consideration
B. signatures of each party
C. agreement
D. competent parties

42. A producer who pays a portion of his or her commission to a client is committing an illegal act known as:

A. rebating.
B. defamation.
C. discrimination.
D. all of the above

43. A person who makes maliciously critical or derogatory statements about another person, with the intent of causing injury, is guilty of:

A. discrimination.
B. coercion.
C. illegal inducement.
D. defamation.

44. The Insurance Commissioner must examine any foreign or alien insurer at least once every:

A. year.
B. five years.
C. six years.
D. ten years.

45. Generally, the Insurance Commissioner will give notice of a hearing to all persons affected at least:

A. 10 days in advance.
B. 15 days in advance.
C. 20 days in advance.
D. 25 days in advance.

Answer Key

1. D
2. C
3. D
4. D
5. D
6. C
7. B
8. A
9. D
10. D
11. D
12. D
13. D
14. C
15. C
16. A
17. B
18. A
19. B
20. A
21. C
22. D
23. B
24. D
25. B
26. A
27. D
28. D
29. B
30. B
31. A
32. C
33. D
34. B
35. C
36. C
37. B
38. B
39. D
40. D
41. B
42. A
43. D
44. B
45. B