STATE CORPORATION COMMISSION, BUREAU OF INSURANCE
Ch. 400 Rules Governing Unfair Claim Settlement Practices

14VAC5-400-10. Purpose and scope.

The purpose of this chapter is to set forth minimum standards for the acknowledgment, investigation, and disposition of claims arising under insurance policies issued pursuant to the laws of the Commonwealth of Virginia. This chapter applies to all persons defined in 14VAC5-400-20 and to all insurance policies except policies of workers' compensation insurance, title insurance, and fidelity and surety insurance.

14VAC5-400-20. Definitions.

The following words and terms when used in this chapter shall have the following meanings unless the context clearly indicates otherwise:

"Agent" means any person authorized to represent an insurer with respect to a claim.

"Claim" means a demand for payment by a claimant and does not mean an inquiry concerning coverage.

"Claimant" means a first party claimant, a third party claimant, a designated legal representative, or a member of the claimant's immediate family designated by the claimant.

"Commission" means the State Corporation Commission.

"Documentation" includes all pertinent communications, including electronic communications and transactions, data, notes, work papers, claim forms, bills, and explanation of benefits forms relative to the claim.

"Estimate" means a written statement of the cost of repairs to an automobile or to property, including any supplements.

"Explanation of benefits" means any form provided by any insurer that explains the amounts covered under a policy or plan and shows the amounts payable by a covered person to a health care provider.

"First party claimant" means an insured, a beneficiary, a policy owner, or an annuitant who asserts a right to payment under an insurance policy arising out of the occurrence of the contingency or loss covered by such policy.

"Insured" means a person covered by an insurance policy with legal rights to the benefits provided by the policy.

"Insurer" means a person licensed to issue or that issues any insurance policy in this Commonwealth. Insurer shall also include surplus lines brokers.

"Investigation" means all activities of an insurer used to make a determination that the claim should be paid, denied, or closed.

"Person" has the same meaning as defined in § 38.2-501 of the Code of Virginia.

"Policy" means insurance policy, contract, certificate of insurance, evidence of coverage, or annuity.

"Proof of loss" means all necessary documentation reasonably required by the insurer to make a determination of benefit or coverage.

"Provider" means any person providing services pursuant to any accident and sickness policy.

"Third party claimant" means any person asserting a claim against an insured or a provider filing a claim on behalf of an insured under an insurance policy.

14VAC5-400-25. Compliance standards.

It shall be a violation of this chapter if any person:

1. Willfully violates any provision of this chapter; or

2. Commits a violation of any provision of this chapter with such frequency as to indicate a general business practice.

14VAC5-400-30. File and record documentation.

A. An insurer's claim files shall be subject to examination by the commission.

B. An insurer shall maintain claim data so that it is accessible and retrievable for examination. Claim data includes the claim number, line of coverage, date of loss and date received, as well as date of payment of the claim, date of denial, or date closed without payment.

C. Detailed documentation shall be maintained for each claim file in order to permit reconstruction of the insurer's activities relating to each claim.

D. Each document within the claim file shall be noted as to date received, date processed, or date mailed.

E. All data and documentation shall be maintained for all open and closed files for the current year and, at a minimum, the three preceding calendar years.

14VAC5-400-40. Misrepresentation of policy provisions.

A. No insurer shall fail to fully disclose to a first party claimant all pertinent benefits, coverages, or other provisions of an insurance policy under which a claim is presented and document the claim file accordingly.

B. No person shall misrepresent benefits, coverages, or other provisions of any insurance policy when such benefits, coverages, or other provisions are pertinent to a claim.

C. No insurer shall deny a claim for failure of a first party claimant to submit to physical examination or for failure of the first party claimant to exhibit property unless there is documentation of breach of the policy provisions in the claim file.

D. No insurer shall deny a claim based on the failure of a claimant to give written notice of loss or give notice of loss within a specified period of time unless either or both requirements are policy conditions. If a policy requires a demonstration of prejudice for a claimant's failure to comply with a notice condition, an insurer shall not be relieved of its obligations under the policy unless the failure to comply with the notice condition prejudices the insurer's rights.

E. No insurer shall request a first party claimant to sign a release that extends beyond the subject matter that gave rise to the claim. An insurer shall not include with any payment or in any accompanying correspondence an indication that payment is "final" or "a release" of any claim unless the policy limit has been paid or a compromise settlement has been agreed to by the first party claimant.

F. No insurer shall issue a payment in partial settlement of a loss or claim for a specific coverage that contains language purporting to release the insurer or its insured from total liability.

14VAC5-400-50. Acknowledgment of pertinent communications.

A. An insurer, upon receiving notification of a claim shall, within 15 calendar days, acknowledge the receipt of such notice to the claimant unless payment is made within such period of time, except that if a provider submits a claim, acknowledgment of the claim is satisfied if payment or denial of the claim is made to the provider within 21 calendar days. If an acknowledgment is made by means other than writing, an appropriate notation of such acknowledgment shall be made in the claim file of the insurer and dated. Notification given by a claimant to an agent of an insurer shall be notification to the insurer.

B. Upon receipt of any inquiry from the commission respecting a claim, an insurer shall furnish a complete response to the inquiry within 15 calendar days of receipt.

C. An appropriate reply shall be made within 15 calendar days on all other pertinent communications from a claimant that reasonably suggest that a response is expected.

D. Upon receiving notification of a claim, an insurer shall promptly provide necessary claim forms, instructions, and reasonable assistance in order for the claimant to comply with the applicable policy conditions and the insurer's reasonable requirements. Compliance with this subsection within 15 calendar days of notification of a claim shall constitute compliance with subsection A of this section.

14VAC5-400-60. Standards for prompt investigation of claims.

A. Within 15 calendar days after receipt by the insurer of any required properly executed proof of loss, a first party claimant shall be advised of the acceptance or denial of the claim by the insurer. If the insurer needs more time to determine whether a claim should be accepted or denied, it shall notify the first party claimant within 15 calendar days after receipt of the proof of loss giving the reasons more time is needed.

B. If an investigation of a first party claim has not been completed, an insurer shall, within 45 calendar days from the date of the notification of a first party claim and every 45 calendar days thereafter, send to the first party claimant a written notice setting forth the reasons additional time is needed for investigation.

14VAC5-400-70. Claims settlement standards applicable to all insurers.

A. Any denial of a claim shall be given to a claimant in writing and the claim file of the insurer shall contain a copy of the denial.

B. An insurer shall provide a reasonable written explanation of the basis for any claim denial. The written explanation shall provide a specific reference to a policy provision, condition, or exclusion, if any.

C. An insurer shall not deny a first party claim on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions.

D. In any case where there is no dispute as to coverage or liability, an insurer shall offer to a first party claimant an amount that is fair and reasonable as shown by the investigation of the

claim, provided the amount so offered is within policy limits and in accordance with policy provisions.

E. An insurer shall not unreasonably refuse to pay any claim in accordance with the provisions of the policy.

14VAC5-400-80. Claims settlement standards applicable to automobile insurance.

A. Where liability is reasonably clear, an insurer shall not recommend that a third party claimant make a claim under its own policy solely to avoid paying a claim under the insured's policy.

B. An insurer shall not require a claimant to travel unreasonably either to inspect a replacement automobile, to obtain a repair estimate, or to have the automobile repaired at a specific repair shop.

C. An insurer shall include the insured's deductible, if any, in subrogation demands. Subrogation recoveries shall be shared on a proportionate basis with the insured, unless the deductible amount has been otherwise recovered. No deduction for expenses can be made from the deductible recovery unless an outside attorney is retained to collect such recovery. The deduction may then be for only a pro rata share of the allocated loss adjustment expense.

D. When an insurer prepares an estimate of the cost of automobile repairs, the estimate shall be an amount for which the damage may reasonably be expected to be satisfactorily repaired. The insurer shall give a copy of the estimate to the claimant and may furnish to the claimant the names of one or more conveniently located qualified repair shops. A total loss valuation shall be provided to the claimant upon request.

E. When the amount claimed is reduced because of betterment or depreciation, all information for such reduction shall be contained in the claim file. Such deductions shall be itemized and specified as to dollar amount and shall be appropriate for the amount of deductions.

F. When an insurer elects to repair and the automobile is repaired in a repair shop designated by the insurer as a repair shop that will repair the automobile for the amount offered by the insurer, the insurer shall cause the damaged automobile to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy and within a reasonable period of time.

G. An insurer shall provide reasonable notice to a claimant prior to termination of payment for automobile storage charges. The insurer shall provide reasonable time for the claimant to remove the automobile from storage prior to the termination of payment.

H. If towing is a result of a covered loss, unless the insurer has provided a claimant with the names of specific towing companies prior to the claimant's use of another towing company, the insurer shall pay all reasonable towing charges irrespective of the towing company used by the claimant.

I. Prior to termination of payment for transportation or rental reimbursement expenses, the insurer shall provide reasonable time for the claimant to receive payment for automobile repairs. In the event of a total loss, the insurer shall provide reasonable time for a claimant to receive payment for a replacement automobile.

14VAC5-400-90. Claims settlement standards applicable to property policies.

When an insurer prepares an estimate of the cost of repairs to property, the estimate shall be an amount for which the damage may reasonably be expected to be satisfactorily repaired. The insurer shall give a copy of the estimate to the claimant.

14VAC5-400-100. Claims settlement standards applicable to accident and sickness insurance, life insurance, and annuities.

A. A life or annuity insurer shall review any notice of claim or proof of loss submitted against one policy to determine if such notice of claim or proof of loss may fulfill the insured's obligation under any other policy issued by that insurer.

B. For accident and sickness claims, an insurer shall provide to the insured an explanation of benefits describing the coverage for which the claim is paid or denied within 21 calendar days of receipt of proof of loss, unless otherwise specified in the policy. If an insurer needs additional time to make a determination, it shall send a notice giving the reasons more time is needed to the insured within the timeframe in this subsection.

C. An insurer shall make available a summary of prescription drug claims electronically or provide a written summary at the request of the insured. A summary of prescription drugs shall describe the amounts covered under the policy, amounts denied, and amounts payable by the insured and insurer.

D. An insurer shall not arbitrarily or unreasonably deny or delay payment of a claim in which liability has become reasonably clear.

14VAC5-400-110. Severability.

If any provision of this chapter or its application to any person or circumstance is for any reason held to be invalid by a court, the remainder of this chapter and the application of the provisions to other persons or circumstances shall not be affected.