California Fair Claims Settlement Practices Regulations Handbook
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Introduction

Sedgwick LLP’s Insurance and Surety Practices Groups are comprised of attorneys who analyze and litigate insurance, surety, and fidelity matters. This handbook is for claims, underwriting, and agency personnel who may be affected by the California Fair Claims Settlement Practices Regulations. Partners Marilyn Klinger, head of Sedgwick’s Construction Practices Group, and Bruce Celebrezze, chair of Sedgwick’s Insurance Practices Group, are co-editors of this handbook. Both are available to answer questions or provide additional information upon request.

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PART ONE
Summary of Fair Claims Settlement Practices Regulations

A. Introduction


California Insurance Code section 790.03, subdivision (h) sets forth 16 claims settlement practices that are deemed to be unfair, and thus prohibited, when an insurer either “knowingly committed” them on a single occasion or committed them with such a frequency so as to make them part of a general business practice. The text of the statute is set forth in Appendix A.

2. Adoption of Claims Practices Regulations

Effective January 15, 1993, the California Insurance Commissioner promulgated subchapter 7.5 [section 2695.1 et seq.] to the California Code of Regulations, Title 10, Chapter 5, so as to specifically set forth minimum, but not exclusive, standards by which unfair claims practices could be measured. The regulations initially took effect January 15, 1993. The regulations were amended, effective May 10, 1997, and further amendments became effective October 4, 2004.

On August 31, 2006, another round of amendments went into effect. These changes were made as part of the 2004 settlement between the California Department of Insurance and various insurance associations, stemming from the lawsuit titled Personal Insurance Federation, et al. v. John Garamendi, Los Angeles Superior Court Case No. 298284.

A copy of the updated regulations is available in Appendix B.

As described in more detail below, insurers are required to provide training and instructions to their claims agents, as well as to adopt and communicate claims handling standards that

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1 The regulations define “insurer” as a person licensed to issue or issuing an insurance policy or surety bond in California, or otherwise transacting the business of insurance in the state. It includes non-admitted insurers, the FAIR Plan, and persons licensed to issue or issuing policies pursuant to assignment by the California Automobile Assigned Risk Plan. However, “insurer” does not include insurance agents and brokers, surplus line brokers, and special surplus line brokers. Regs., § 2695.2, subd. (i).

2 Regs., § 2695.2, subd. (l) defines the term “knowingly committed” as “performed with actual, implied or constructive knowledge, including, but not limited to, that which is implied by operation of law.”

3 Regs., § 2695.1, subd. (b). This subdivision states that other practices, acts, or methods not specifically delineated may also be an unfair claims handling practice. Therefore, see the Unfair Claims Practices Act (Ins. Code, §§ 790 et seq.). As a general rule, because the prohibition in the Unfair Claims Practices Act is against “unfair” or “deceptive” conduct, the Commissioner may deem claims handling or settlement practices that are deceptive, unreasonable or unreasonably protracted to be violations.

4 The regulations define “claims agent” as “any person employed or authorized by an insurer, to conduct an investigation of a claim on behalf of an insurer or a person who is licensed by the Commissioner to conduct investigations of claims on behalf of an insurer...” Regs., § 2695.2, subd. (d).
comport with the regulations to their claims agents and claims handlers on annually and within 90 days of any revisions to the regulations.  

3. Definitions

The regulations define the meanings of 25 terms as they are used throughout the regulations. When used in the body of this handbook, these terms are italicized, and each is defined in a footnote the first time it appears.

4. Classes of Insurance Affected by Regulations

a. Admitted Insurers

The fair claims handling regulations apply to insurers issuing all classes of insurance save for workers’ compensation, health care malpractice liability coverage, self-insured or self-funded ERISA plans, which are not also multiple employer welfare plans, and self-funded or self-insured plans lawfully conducting business in California.

Special standards for claim settlements apply to automobile insurance, including the Auto Body Repair Consumer Bill of Rights, first party residential and commercial property insurance policies, surety insurance, and life and disability insurance claims. The regulations are intended to apply to and govern the claims activities of any entity that transacts the business of insurance in California, including non-admitted insurers and participants in the California FAIR Plan and the California Automobile Assigned Risk Plan.

The regulations further apply to claims brought by either first or third parties to the insurance contract, their representatives (including attorneys), as well as public adjusters and family members where designated in writing.

b. Non-admitted Insurers

Non-admitted insurers are within the ambit of the California Unfair Claims Settlement Practices Act, and, to the extent they issue policies or transact business in California, the Com-

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5 Regs., § 2695.6, subd. (a-b).
6 Regs., § 2695.2.
7 Regs., § 2695.1, subd. (b)(1-4).
8 Regs., § 2695.8 and § 2695.85.
9 Regs., § 2695.9.
10 Regs., § 2695.10.
11 Regs., §2695.11.
12 Regs., § 2695.2, subd. (c), and § 2695.5, subd. (c).
13 Ins. Code § 790.01 provides that the Unfair Claims Practices Act applies to “Lloyd’s insurers, surplus lines brokers and special surplus lines brokers, as well as all other persons engaged in the business of insurance.”
missioner's regulations. Consequently, non-admitted insurers are required to comply with the provisions of the Fair Claims Settlement Practices Regulations pertaining to claims file documentation, claims acknowledgment, unfair claims practices, and unfair settlement practices. However, non-admitted insurers are subject to neither the inspection nor the penalty provisions of the regulations, as these apply only to licensees.

5. Role of Third Party Information Vendors

A licensee is not excused from compliance with the regulations if its actions are based on inaccurate, erroneous, or untimely information provided to the licensee by a third party vendor.

B. Claims Handling Duties

1. Record-Keeping Requirements

The claims files of licensees are subject to examination by the Commissioner. The files are required to be complete as to the individual claim so as to allow the Commissioner to reconstruct pertinent events and dates on which events occurred.

To facilitate examination of claims handling records, all insurers are required to:

- Maintain retrievable claim data for examination for the current year as well as the preceding four years in a form that allows inspection of the following:
  - Claim number;
  - Line of coverage;
  - Date of loss;
  - Date claim paid; and
  - Date claim denied or closed without payment.
- Chronicle in each file the dates the licensee received, processed, and transmitted or mailed each key document in the file.
- Preserve claims file material for the current year and the four previous years in hard copy form or in a form that can be duplicated.

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14 California courts have reasoned that non-admitted insurers “may properly be regulated when they have sufficient contacts with the regulating state so as to give the latter a ‘substantial interest’ in the transactions.” People v. United Nat’l Life Ins. Co., 66 Cal. 2d 577, 589 (1967).
15 Although the prohibition against unfair claims settlement practices apply to all insurers, non-admitted insurers are presumptively exempt from certain provisions of the regulations because the regulations provide for inspection and penalties only upon licensees, and a non-admitted insurer is not within the ambit of the definition of the term licensee. Regs., § 2695.2, subd. (m) defines “licensee” as “any person that holds a license or Certificate of Authority from the Insurance Commissioner, or any other entity for whom the Insurance Commissioner’s consent is required before transacting business in the State of California or with California residents”; § 2695.3 subd. (a) [inspection of licensees’ files]; § 2695.12 [penalties]. However, all insurers are required to maintain specified claim data. Regs., § 2695.3 subd. (b).
16 Regs., § 2695.1, subd. (g).
17 Regs., § 2695.3, subd. (a).
18 Regs., § 2695.3, subd. (b).
2. Insurance Policy Provision Disclosure Requirements

Insurers are required to divulge the following information to first party claimants and third party claimants presenting claims:

- Benefits;
- Coverage;
- Time limits or other applicable insurance policy provisions that apply to the claim; and
- Any additional benefits that may be implicated by the claim.

Disclosure requirements specific to surety insurers are addressed in Part Two of this Handbook.

3. Prohibited Claims Handling Conduct

a. Discrimination

Insurers may not discriminate in claims settlement practices based upon the age, race, gender, income, religion, language, sexual orientation, ancestry, national origin, or physical disability of the claimant, nor based upon the area in which the property or person insured is located.

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19 The regulations define “first party claimant” as “any person asserting a right under an insurance policy as a named insured, other insured or beneficiary under the terms of that insurance policy, and including any person seeking recovery of uninsured motorist benefits.” Regs., §2695.2, subd. (f).

20 The regulations define “third party claimant” as “any person asserting a claim against any person or the interests insured under an insurance policy.” Regs., § 2695.2, subd. (x).

21 Regs., § 2695.4, subd. (a). This subdivision does not apply to surety bonds, only insurance policies.

22 The regulations define “insurance policy” and “policy” as “the written instrument in which any certificate of group insurance, contract of insurance, or non-profit hospital service plan is set forth. For the purposes of these regulations the terms insurance policy or policy do not include ‘surety bond’ or ‘bond’…” Regs., §2695.2, subd. (j).


24 The regulations define “claimant” as meaning a first or third party claimant (as defined in the regulations), or “any person who asserts a right of recovery under a surety bond, an attorney, any person authorized by operation of law to represent the claimant, or any of the following persons properly designated by the claimant in the manner specified in subsection 2695.5(c): an insurance adjuster, a public adjuster, or any member of the claimant’s family.”

25 The regulations define “person” as “any individual, association, organization, partnership, business, trust, corporation or other entity.” Regs., § 2695.2, subd. (q).

26 Regs., § 2695.7, subd. (a).
b. Generally Prohibited Acts

The following acts are forbidden:

• Failing to disclose to a first party claimant or beneficiary\(^{27}\) all benefits, coverage, time limits or other provisions of an insurance policy that may apply to the claim presented by the claimant.\(^{28}\) (Forbidden acts specific to surety insurers regarding disclosure are discussed in Part Two of this handbook.)
• Denying a claim for failure to exhibit property unless the claim file documents reflect either a reasonable demand by the insurer and an unfounded refusal by the claimant or a breach of a contract provision mandating the production of property;\(^{29}\)
• Requiring a first party claimant to provide notice of claim\(^{30}\) or proof of claim\(^ {31}\) within a specified period of time unless set forth in the contract;\(^{32}\)
• Requesting an unrepresented claimant to sign a release that is broader in scope than the subject of the claim for which payment is being made unless the effect of the release is both disclosed and fully explained to the claimant in writing; however, a waiver of the provisions of California Civil Code section 1542 (providing that a release does not include claims not then known) is permitted if disclosed and explained.\(^{33}\) This applies to all forms of insurance.
• Issuing checks in partial payment that are accompanied by language releasing the insurer, insured, or principal\(^{34}\) in full unless the insurance policy or surety bond\(^ {35}\) limit has been paid, or a compromise settlement has been mutually agreed to as to coverage and amount payable under an insurance policy or surety bond.\(^{36}\) This applies to all forms of insurance.

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\(^{27}\) The regulations define “beneficiary,” for the purpose of life and disability claims, as “the party or parties entitled to receive the proceeds or benefits occurring under the policy in lieu of the insured”; or, for the purpose of surety claims, “a person who is within the class of persons intended to benefit from the bond.” Regs., § 2695.2, subd. (a).
\(^{28}\) Regs., §2695.4, subd. (a).
\(^{29}\) Regs., § 2695.4, subd. (c).
\(^{30}\) The regulations define “notice of claim” as “any written or oral notification to an insurer or its agent that reasonably apprises the insurer that the claimant wishes to make a claim against a policy or bond issued by the insurer and that a condition giving rise to the insurer’s obligations under that policy or bond may have arisen.” Regs., § 2695.2, subd. (n).
\(^{31}\) “Proof of claim” is defined as “any documentation in the claimant’s possession submitted to the insurer [including a surety] which provides any evidence of the claim and that supports the magnitude or the amount of the claimed loss.” Regs., § 2695.2, subd. (s).
\(^{32}\) Regs., § 2695.4, subd. (d).
\(^{33}\) Regs., § 2695.4, subd. (e)(1-2).
\(^{34}\) The regulations define “principal” as “the person whose debt or other obligation is secured or guaranteed by a bond and who has the primary duty to pay the debt or discharge the obligation.” Regs., § 2695.2, subd. (f).
\(^{35}\) “Surety bond” or “bond” is defined as “the written instrument in which a contract of surety insurance is set forth.” Regs., § 2695.2, subd. (w).
\(^{36}\) Regs., § 2695.4, subd. (f).
• Requiring a first party claimant to submit duplicative proofs of claim where the insurer may provide coverage under more than one policy.\(^{37}\)
• Requiring the claimant to refrain, withdraw, or forbear from submitting a complaint to the Commissioner as a condition precedent to the settlement of a claim.\(^{38}\) This applies to all forms of insurance.

### c. Threatening Impairment of Rights

A third party claimant may not be informed that his or her rights will be abridged if a form or release is not completed within a specified period unless the purpose of advising the claimant of a time deadline is to inform of an applicable statute of limitations, policy provision, or governmental tort claim statute.\(^{39}\)

### d. Lie Detector Tests

Insurers may not request or require insureds to submit to polygraph examination unless authorized by the insurance policy and state law.\(^{40}\)

### 4. Duties Upon Receipt of Notice of Claim

Upon receipt of notice of claim, insurers have various duties. These duties apply to all forms of insurance.

#### a. Provide Copy of Ins. Code section 790.03

Upon receiving notice of a claim, every insurer as expressly defined\(^{41}\) must, within 15 days after receiving the claim, provide the insured with a legible copy of Ins. Code section 790.03 in at least 12-point type and a notice stating:

In addition to section 790.03 of the Insurance Code provided here, Fair Claims Settlement Practices Regulations govern how insurance claims must be processed in this state. These regulations are available at the Department of Insurance Internet site, www.insurance.ca.gov. You may also obtain a copy of these regulations free of charge from this insurer.\(^{42}\)

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\(^{37}\)Regs., § 2695.4, subd. (g).

\(^{38}\)Regs., § 2695.7, subd. (o).

\(^{39}\)Regs., § 2695.7, subd. (i).

\(^{40}\)Regs., § 2695.7, subd. (j).

\(^{41}\)Only residential property insurers, California Earthquake Authority, property damage insurers for common interest developments, and property damage insurers for residential units. Ins. Code § 790.031.

\(^{42}\)Ins. Code §790.034(b)(1).
Every insurer must send a copy of sections 2695.5, 2695.7, 2695.8, and 2695.9 of the regulations within 15 days of an oral or written request for them from the insured.43

b. Transmit Claims Notification

Licensees, insurance agents,44 and claims agents are required to immediately transmit notice of claims to the insurer.45 Failure of a licensee, insurance agent, or claims agent to promptly transmit notice is imputed to the insurer except where the policy was issued pursuant to the California Automobile Assigned Risk Program.46

c. Acknowledge Receipt of Claim

Notices of claims must generally be acknowledged in writing, or the acknowledgment be documented in the claims file, within 15 days of the receipt of a notice of claim. The only exceptions are where the insurer makes payment or receives notice of legal action within that time period.47

Notice of claim is essentially receipt of oral or written communication by the insurer or its agent that substantially informs the insurer that the claimant wishes to make a claim and that a condition giving rise to the insurer’s obligations may have arisen. Written notice may not be required unless specified in the insurance contract.48 The regulations do not define “agent.” Accordingly, insurers should probably use its plain and ordinary meaning.

A notice of claim does not include any written or verbal communication provided solely for informational or incident reporting purposes.49

d. Provide Forms, Instruction and Assistance

Upon receiving a notice of claim, the insurer is required to immediately (but not later than 15 days) provide the necessary claim forms, instructions and reasonable assistance, including detailing the information the claimant must provide.50

43 Ins. Code §790.034(b)(2).
44 The regulations define “insurance agent” (1) to have the same meaning as that used in 31 of the California Insurance Code; or, (2) the same meaning as the term “life agent” as it is used in section 32 of the California Insurance Code; or (3) any person who has authority or responsibility to notify an insurer of a claim upon receipt of a notice of claim by a claimant; or, (4) an underwritten title company. Regs., § 2695.2, subd. (h).
45 Regs., § 2695.5, subd. (d).
46 Regs., § 2695.5, subd. (e)(1).
47 The regulations define “notice of legal action” as “notice of an action commenced against the insurer with respect to a claim, or notice of action against the insured received by the insurer, or notice of action against the principal under a bond, and includes any arbitration proceeding.” Regs § 2695.2, subd. (o).
48 Regs., § 2695.2 subd. (n); § 2695.5, subd. (f).
49 Regs., § 2695.5, subd. (e) (1) [acknowledgment]; § 2695.2, subd. (n) [notice of claim]; §2695.2 subd. (o) [notice of legal action].
50 Regs., § 2695.5, subd. (e)(2).
e. Commence Investigation of Claim

Insurers are required to immediately, but not more than 15 days\(^{51}\) after receiving notice of claim, commence any necessary claims investigation.\(^{52}\)

5. Reply to Claimants’ Communications Within 15 Days

Separate and distinct from receipt of a notice of claim, licensees are required to respond as soon as is practicable, but in any event no more than 15 days after receipt of any communication from a claimant that suggests a reply is expected. The response must be complete and based upon the facts as then known.\(^{53}\) This requirement ends when the licensee receives a notice of legal action.

6. Reply to Department of Insurance Inquiries Within 21 Days

Licensees are required to furnish a complete written reply to inquiries concerning claims, whether oral or written, received from the Department of Insurance within 21 days of receipt.\(^{54}\)

C. Acceptance or Rejection of Claims

1. Claims Determinations Required Within 40 Days

An insurer must accept or reject, in whole or in part, both first and third party claims, immediately, but no later than 40 days after receiving a proof of claim.\(^{55}\)

A proof of claim is any evidence or documentation in the possession of the insurer, whether submitted by the claimant or obtained by the insurer in the course of its investigation, showing any evidence of the claim and reasonably supporting the magnitude or amount of the claimed loss.\(^{56}\)

\(^{51}\) Regs., § 2695.5, subd. (e)(3) [time limit].

\(^{52}\) The regulations define “investigation” as “all activities of an insurer or its claims agent related to the determination of coverage, liabilities, or nature and extent of loss or damage for which benefits are afforded by an insurance policy, obligations or duties under a bond, and other obligations or duties arising from an insurance policy or bond.” Regs., § 2695.2, subd.(k).

\(^{53}\) Regs., § 2695.5, subd. (b).

\(^{54}\) Regs., § 2695.5, subd. (a).

\(^{55}\) Regs., § 2695.7, subd. (b).

\(^{56}\) Regs., § 2695.2, subd. (s).
2. Extensions of 40-Day Period

a. Inability to Make Determination as Basis for Extension

If an insurer requires more than 40 days to make a claims determination, the insurer must provide the claimant with written notice that additional time is required to make a determination. The insurer’s notice must specify what further information is required in order for the insurer to reach a decision and state the continuing reasons for the insurer’s inability to make a determination.\(^{57}\)

If an insurer’s inability to make a determination continues, the continuing reasons for the inability to resolve the claim must be communicated in writing to the claimant. This notice must be provided every 30 days thereafter until either a resolution is accomplished or notice of legal action is served.\(^{58}\)

In the event a claims determination is contingent upon some future event, compliance is met by an insurer’s notice to the claimant of the existence of this fact as well as an estimate of when the matter will resolve. Insurers need not disclose information that would inform a claimant that his or her claim was being investigated for suspected fraud.\(^{59}\)

b. Investigation of False and Fraudulent Claims as Basis for Extension

Where a reasonable basis exists to believe that a claim is false or fraudulent (as provided by California Insurance Code sections 1871.1, subdivision (a) [property, casualty and health claims] and 1871.4, subdivision (a) [workers’ compensation claims]), the time period in which to act on a claim is either:

- Doubled to 80 days; or
- Suspended until otherwise ordered by the Commissioner so long as the insurer has:

\(^{57}\) Regs., § 2695.7, subd. (c)(1).
\(^{58}\) Id.
\(^{59}\) Regs., § 2695.7, subd. (c)(2).
- reported the matter to the Bureau of Fraudulent Claims in the manner prescribed in Insurance Code section 1872.4; and
- demonstrated diligence in attempting to determine whether the claim is in fact false or fraudulent within the 80-day period.  

\[\text{c. Invalid Reasons to Extend Period}\]

Resolution of claims may not be delayed by:

- An insurer’s persistence in seeking information not reasonably required for the determination of the claim;\(^{61}\)
- In the case of first party claims, an assertion by the insurer that others are responsible for payment, unless the assertion is supported by policy provisions, statutes, or regulations, including those concerning coordination of benefits.\(^{62}\)

3. Required Claims File Documentation

A denial, if based on an interview or telephonically communicated information, must have such information contained in the claims file.\(^{63}\)

4. Contents of Notice of Claims Decisions

a. First Party Claims

Communications of claims decisions as to claims brought by first party claimants\(^{64}\) that are denied or rejected in whole or in part, must be in writing and must also satisfy the following requirements:

- They must include a statement of all the grounds for the determination as well as the factual and legal bases for each reason for the decision then within the insurer’s knowledge.
- Where a claims decision is based upon a specific statute, applicable law or policy

\[\text{\(^{60}\) Regs., § 2695.7, subd. (k)(1-2).}\]
\[\text{\(^{61}\) Regs., § 2695.7, subd. (d).}\]
\[\text{\(^{62}\) Regs., § 2695.7, subd. (e).}\]
\[\text{\(^{63}\) Regs., § 2695.7, subd. (l).}\]
\[\text{\(^{64}\) Regs., § 2695.2, subd. (f) defines “first party claimant” to include the named insured, other insured, beneficiary or person seeking recovery of uninsured motorist benefits.}\]
language, the communication must include both a reference to the statute, law or policy provision relied upon as well as an explanation of its application to the facts of the claim.\textsuperscript{65}

b. Third Party Claims

Communications of claims decisions as to claims of third parties that are denied or rejected in whole or in part, or as to which liability or damages are disputed, must be in writing.\textsuperscript{66}

c. Exception to Notice Requirement: Fraud Investigation

As noted above, an insurer’s notice must recite all facts considered by the insurer in accepting or denying a claim. However, to discourage fraudulent claims, an insurer, whether as to a first party or third party claimant, who is investigating a potential fraudulent claim, need not disclose information alerting a claimant to the fact that an investigation as to fraud is taking place.\textsuperscript{67}

d. Notification Requirements Applicable to All Claims

1) Notification of Right to Have Denial Reviewed by Department of Insurance

Each communication of a claims decision denying or rejecting a claim (in whole or in part), must also provide:

- Notice to the claimant that if he or she believes the action taken by the insurer is wrongful, the matter may be reviewed by the Department of Insurance; and
- The address and telephone number of the Department’s claim practice review

\textsuperscript{65} Regs., § 2695.7, subd. (b)(1).
\textsuperscript{66} Regs., § 2695.7, subd. (b)(1).
\textsuperscript{67} Regs., § 2695.7, subd. (c)(2).
Part One
Summary of Fair Claims Settlement Practices Regulations

The claims handling unit.

That address is:

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013
1-800-927-HELP (4357) or 213-897-8921

2) Notice of Expiring Statute of Limitations Period

Unless the claimant is represented by counsel, every insurer must provide written notice of any statute of limitation or other time period requirement upon which the insurer may rely to deny a claim. The notice must be given not less than 60 days before the expiration date. Failure to provide such notice may result in a tolling of the statute of limitations.

There is no time limit in the regulations as to how soon before the expiration date the insurer can give the notice. Accordingly, an insurer can arguably give the notice the first time the insurer communicates with the claimant.

If the claim notice is first received within the final 60 days that a claim may be timely brought, notice must be provided immediately. First party uninsured motorist claimants must be provided with 30 days' notice of the potential expiration of any applicable limitation period, unless the claim notice is first received within the 30 days before expiry of the limitation, in which case notice must be immediate.

The regulations simply require that the insurer give notice of any statute of limitation or other time period requirement. They do not require the insurer to determine the expiration date except to the extent it affects when the insurer gives notice. They also do not require the insurer to give notice of that expiration date, only the statute or the time period requirement.

Arguably, this requirement applies to any claims handling that occurs on or after August

68 Regs., § 2695.7, subd. (b)(3).
69 Regs., § 2695.7, subd. (f).
71 Regs., § 2695.7, subd. (f).
Accordingly, insurers should provide such notices to all claimants with pending claims, regardless of the status of the insurer’s investigation.

3) Subrogation

(a) Notification to First Party Claimants

Insurers are required to provide written notice to a first party claimant whether the insurer desires to exercise a right of subrogation. If an insurer does not elect to subrogate, or determines to forego further efforts to subrogate once such efforts have begun, it must notify the first party claimant that any effort at effecting a recovery is the first party claimant’s responsibility.

(b) No Notice Regarding Subrogation

Notice is not required where:

- The deductible has been waived;
- The first party claimant is not required to pay a deductible under the insurance policy;
- The total loss sustained is within the amount of the deductible; or
- There is no legal basis for subrogation.

(c) Subrogation Demand Must Include Deductible

Subrogation demands must include the first party claimant’s deductible. Recovery must be shared with the first party claimant on a proportionate basis unless the first party claimant has otherwise recovered the full amount of the deductible. The insurer may not reduce the amount of the deductible recovered for expenses unless the insurer has actually retained the services of an outside attorney or collection agency to effect recovery, in which case the recovery may be reduced by only a pro rata share of the allocated expense.
D. Settlement Offers and Payment of Accepted Settlements

1. Unreasonably Low Settlement Offers Prohibited

*Insurers* may not attempt to effect a settlement by making offers that are unreasonably low, as measured by the following factors:

- The extent of the *insurer’s* consideration of the *claimant’s* evidence in support of the valuation 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 input of the claims handler as to the amount of damages;
- The extent to which the *insurer* considered the advice of counsel that there was a substantial likelihood of an excess of limits recovery;
- The procedures employed by the *insurer* in determining the dollar value of property damage;
- The extent to which the *insurer* considered the liability of the insured and potential verdict;
- Any other credible evidence presented to the Commissioner that demonstrates that the amount of any settlement offer, whether to a *first party claimant* or for a *third party claim* is below what an informed, reasonable *person* would have offered.

2. Prohibited Settlement Practices

   a. No Set-Off or Subrogation of Overpayment to Providers

*Insurers* may not seek recovery or set-off of payments from insureds based on overpayment to a health care services provider except where the claim has been proven to be false or fraudulent. The regulation is subject to coordination with the provisions of Insurance Code

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75 Regs., § 2695.7, subd. (g)(1-7).
section 10123.145, which generally provides for a mechanism for recoupment of medical benefits from a provider who has been overpaid.

b. Limitation on Medical Examinations

An insurer may only request a medical examination for determining its obligation under an insurance policy provision where it has a good faith belief that such an examination is necessary.\(^76\)

3. Tender of Settlement Payments Within 30 Days

a. Payments Required Where Coverage and/or Liability Admitted

The regulations provide that insurers must tender immediate payment, but in no event more than 30 days of claims resolution, where the amount of a claim has been determined and is not in dispute (and, where necessary, a fully executed release has been received).\(^77\)

b. Payments Required Where Multiple Coverages Involved

Where multiple coverages are at stake, and:

- Payment would terminate the insurer’s known liability under a single coverage without impairing the interests of the insured;
- The amount of payment is not in dispute; and
- The recipient’s identity is known,

then payment must be tendered immediately or no later than 30 days after determination of the above facts, unless the insurance policy provides for a waiting period after confirmation of liability and coverage before payment of policy benefits.\(^78\)

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\(^76\) Regs., § 2695.7, subd. (n).
\(^77\) Regs., § 2695.7, subd. (h).
\(^78\) Regs., § 2695.7, subd. (h).
c. Payment of Claims Under Insurance Coverage Controlled by Statute

1) Hospital, Medical, or Surgical Coverage

*Insurers* issuing group or individual policies of disability insurance covering hospital, medical or surgical expenses are subject to the provisions of California Insurance Code section 10123.13, which generally provides for reimbursement of uncontested claims within 30 days, requires notice be given in the event a claim is being contested, and requires interest to be paid to the recipient on the amount owing if the claim is not timely paid.  

2) Life Coverage

Insurers admitted to transact life insurance are subject to the provisions of California Insurance Code section 10172.5, which generally provides for payment of insurance policy proceeds within 30 days after death without interest accruing.

3) Automobile Collision and Comprehensive Coverage

*Insurers* issuing collision and comprehensive policies are subject to the provisions of California Insurance Code section 560, which generally provides for payment for repairs authorized by the *insurer* no later than 10 days after receiving a statement.

4) Title Insurance

*Insurers* issuing title insurance are made subject to the time provisions stated in the regulations (30 days) or alternatively required to act immediately or within 30 days after acceptance of the claim to resolve the problem initially giving rise to the claim.

5) Mortgage Guaranty Insurance

*Insurers* issuing mortgage guaranty insurance are required to tender payment within 60 days after confirmation of coverage and/or liability.

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79 Regs., § 2695.7, subd. (h)(1).
80 Regs., § 2695.7, subd. (1).
81 Regs., § 2695.7, subd. (h)(1).
82 Regs., § 2695.7, subd. (h)(2).
83 Regs., § 2695.7, subd. (h)(1).
E. Adoption of Standards, Training, and Certification

Every **insurer** must adopt and communicate to its **claims agents** written standards for the prompt **investigation** and processing of claims. The must do so within 90 days of any revisions to the regulations.\(^{84}\)

All **licensees** are obligated to provide thorough and adequate training regarding the regulations to all **claims agents** (other than attorneys).\(^{86}\)

**Licensees** that are business entities (i.e., not individuals) are required to have a principal annually certify in writing and under penalty of perjury that:\(^{87}\)

- The **licensee**’s claim adjusting manual contains a complete copy of the regulations and all amendments;
- Clearly written instructions regarding procedures to effect compliance with the regulations have been provided to all **claims agents**; or
- Where insurance adjusters\(^{88}\) are retained to handle claims, either:
  - the adjusters have been trained by the **licensee** each year; or
  - the insurance adjuster annually has stated in writing and under penalty of perjury that he or she has read and understands the regulations or has successfully completed a training seminar explaining them.

Individual **licensees** must simply state annually, in writing and under penalty of perjury, that he or she has read and understands the regulations and applicable amendments.\(^{89}\)

Appendix C contains sample certifications for **licensees**, **claims agents**, and independent adjusters.

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\(^{84}\) Regs., § 2695.6, subd. (a).

\(^{85}\) There is a slight ambiguity as to the timing for this requirement. As noted above, Regs., § 2695.6, subd. (a) requires the standards to be communicated 90 days of any revisions. However, Regs., § 2695.14, subd. (b) provides that **licensees** shall do so, “prior to the compliance date of these regulations....” Regs., § 2695.14, subd. (a) provides that the compliance date is 90 days after the amendments were filed with the Secretary of State, which was June 1, 2006. On balance, it would appear that as long as the standards are communicated to **claims agents** by December 1, 2006, **licensees** will be in compliance.

\(^{86}\) Regs., § 2695.6, subd. (b).

\(^{87}\) Regs., § 2695.6, subd. (b)(2).

\(^{88}\) As defined in California Insurance Code § 14021.

\(^{89}\) Regs., § 2695.6, subd. (b)(1).
F. Settlement Standards for Specialty Coverages

1. Automobile Insurance

a. Introduction

Section 2695.8 of the regulations is devoted solely to standards for the adjustment and settlement of personal and commercial automobile insurance claims.

b. Prohibited Practices

Automobile insurers may not:

• Where liability and damages are reasonably clear, recommend that a third party claimant make claim against his or her own coverage to avoid paying the claim under the insurer’s policy;  

• Require that an automobile be repaired at a specific shop;

• Refer a vehicle to a specific shop unless they have met the requirements set forth in section 758.5 of the Insurance Code, which include:
  - Guidance is requested by a claimant;
  - The claimant has been informed in writing of the right to select the shop; and
  - The insurer causes the vehicle to be restored to its pre-loss condition with no additional charge to the claimant than provided for in the insurance policy or allowed by the regulations;

• Require a claimant to travel an unreasonable distance to:
  - Inspect a replacement vehicle;
  - Conduct an inspection of the vehicle;
  - Obtain a repair estimate; or
  - Have the vehicle repaired at a specific shop.

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90 Regs., § 2695.8, subd. (d).
91 Regs., § 2695.8, subd. (e)(1).
92 Regs., § 2695.8, subd. (e)(2).
93 Regs., § 2695.8, subd. (e)(3).
c. Total Loss ACV or Replacement Provisions

Insurance policies containing provisions for total losses on the basis of actual cash value or replacement with a comparable auto are required to settle losses as follows:  

1) Cash Settlement Procedures

Cash settlement is based on actual cost, minus the deductible, for the purchase of a comparable vehicle including taxes, license and other fees arising from transfer of title. The actual cost must be derived from one of the following and must be fully itemized and explained in writing for the claimant:  

- Average costs of two or more comparable automobiles that are available in the local market area in the last 90 days;  
- Average quotes from two or more licensed dealers in the local market area when comparable vehicles are not available;  
- A computerized automobile valuation service that produces statistically valid fair market values within the local market; or  
- In the event of settlement on a basis other than ACV or replacement cost, the determination of total loss value must be supported by claims file documentation with any deductions such as salvage being clear, explicit, itemized and appropriate when translated into dollar amount. The insurer must reasonably verify that the value assigned is accurate and representative as to market value of a comparable vehicle in the local market area.

2) Replacement Procedures

(a) General Duties Regarding Replacement Vehicles

Specified comparable replacement vehicles must be provided at no cost to the claimant other than payment of the insurance policy deductible. The offer and/or rejection of a replacement

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94 Regs., § 2695.8, subd. (b). This provision was amended in 2006 to apply to third party claims as well as to first party claims so that the same total loss valuation standards apply to each.  
95 Regs., § 2695.8, subd. (b)(4).  
96 Regs., § 2695.8, subd. (b)(4)(A). In determining the cost of a comparable vehicle, the insurer may use either the asking price or actual sale price of the automobile. Regs., § 2695.8, subd. (b)(2).  
97 Regs., § 2695.8, subd. (b)(4)(B).  
98 Regs., § 2695.8, subd. (b)(4)(C)  
99 Regs., § 2695.8, subd. (b)(4)(D).
vehicle must be documented in the claims file. “Comparable vehicle” is specifically defined as being the same brand, same or newer model year, similar body type, with similar mileage and options as the vehicle being replaced. Differences in options and/or mileage permit fair adjustment. Lastly, a comparable vehicle must be:

- In as good or better condition than the vehicle being replaced; and
- Available for inspection within a reasonable distance of where an insured resides.

(b) Duties Where Amount of Settlement Insufficient

In first party total loss claims, if an insurer is notified within 35 days of the claimant’s receipt of the settlement that the sum provided is insufficient to provide for purchase of a comparable vehicle, the carrier must reopen its files and do the following:

- Locate a comparable automobile for the amount provided and tell the insured where the vehicle may be found or offer a replacement vehicle as described above in the local market area;
- Pay the difference between the gross settlement and actual cost of the comparable vehicle located by the claimant, or purchase the vehicle for the claimant, or resort to the appraisal provisions of the insurance policy.

(c) Exception to File Reopening — Insured Advised of Specific Comparable Vehicle

An insurer will be exempt from the file reopening requirement where, at the time of the settlement, the insurer advised the claimant in writing as to the identity of a specific comparable vehicle (as described above with differences in options and mileage fairly adjusted) available

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100 Regs., § 2695.8, subd. (b)(5).
101 Regs., § 2695.8, subd. (b)(2).
102 Regs., § 2695.8, subd. (b)(5).
103 Regs., § 2695.8, subd. (c).
104 Regs., § 2695.8, subd. (c)(1).
105 Regs., § 2695.8, subd. (c)(2).
106 Regs., § 2695.8, subd. (c)(3).
for purchase at the time of the final settlement offer for the *gross settlement amount*.\(^{107}\) The advice to the claimant must include:\(^{108}\)

- VIN; or
- Licensed dealer’s stock or order number; or
- Vehicle’s license plate number.

3) Partial Losses — Estimates and Repair Procedures

(a) Insurer Prepared Estimates

For partial losses, *insurers* must provide *claimants* with estimates supporting settlements where the estimate is prepared by or for the *insurer*. The estimate must conform to the requirements of the *insurance policy* and be sufficient to provide for quality restoration.\(^{109}\)

(b) Procedure Where Insurer Estimate is Insufficient

Where a *claimant* obtains an estimate for an amount greater than the one prepared by or for the *insurer*, the *insurer* has the following options:

- Pay the difference;\(^{110}\)
- Provide the *claimant* with the name of at least one shop that will make the repairs for the amount stated in the *insurer’s* estimate, and then cause the car to be restored to its prior condition at no additional cost to the *claimant* other than as stated in the *insurance policy* or as otherwise allowed by law. The *insurer* is required to document these communications,\(^ {111}\) or
- Reasonably adjust written estimates obtained by the shop chosen by the insured.\(^ {112}\)

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\(^{107}\) Regs., § 2695.8, subd. (c)(4). The regulations define “gross settlement amount” as the amount tendered plus the amount deducted as provided in the *policy* in the settlement of an automobile total loss claim. Regs., § 2695.2, subd. (g).

\(^{108}\) Regs., § 2695.8, subd. (c)(4)(A-C).

\(^{109}\) Regs., § 2695.8, subd. (f).

\(^{110}\) Regs., § 2695.8, subd. (f)(1).

\(^{111}\) Regs., § 2695.8, subd. (f)(2).

\(^{112}\) Regs., § 2695.8, subd. (f)(3).
(c) Use of Non-Original Equipment Replacement Parts

*Insurers* are prohibited from requiring the use of non-original replacement parts unless the following conditions are met:\(^{113}\)

- The parts are equal to those offered by the original equipment manufacturer with respect to kind, quality, safety, fitness, and performance;\(^{114}\)
- The insurer assumes the cost of modifying the non-original parts if required to effect the repair;\(^{115}\)
- The *insurer* warrants that the parts are equivalent to those of the original equipment manufacturer;\(^{116}\) and
- All replacement crash parts\(^{117}\) manufactured after January 15, 1993, supplied by repair shops bear the indelible identification of the manufacturer, which identification is, to the extent possible, accessible after installation;\(^{118}\) and
- The use of non-original replacement parts is disclosed to the *claimant* as required by Business and Professions Code section 9875.\(^{119}\)

(d) Claimant May Not Be Required to Supply Replacement Parts

*Insurers* may not require the *claimant* to supply parts needed to effect repair.\(^{120}\)

4) Rules for Deduction Based upon Betterment, Depreciation, or Salvage

(a) Betterment or Depreciation Adjustments — When Allowed

Deductions for betterment or depreciation must be justified by explicit and itemized documentation in the claim file, specified as to dollar amount, and must be an accurate reflection of the value of the reductions. The basis for the taking of betterment or depreciation deductions must be completely explained to the *claimant* in writing and a copy of the explanation must be retained in the claim file.\(^{121}\)

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\(^{113}\) Regs., § 2695.8, subd. (g).
\(^{114}\) Regs., § 2695.7, subd. (g)(1).
\(^{115}\) Regs., § 2695.7, subd. (g)(2).
\(^{116}\) Regs., § 2695.7, subd. (g)(3).
\(^{117}\) The regulations define “replacement crash part” as a replacement for “any of the nonmechanical sheet metal or plastic parts which generally constitute the exterior of a motor vehicle, including inner and outer panels.” Regs., § 2695.2, subd. (u).
\(^{118}\) Regs., § 2695.8, subd. (g)(4).
\(^{119}\) Regs., § 2695.8, subd. (g)(5).
\(^{120}\) Regs., § 2695.7, subd. (h).
\(^{121}\) Regs., § 2695.8, subd. (i).
Labor expenses may not be included in depreciation or betterment deductions for first party claims unless the *insurance policy* expressly permits the depreciation of labor.\(^{122}\) Adjustments are allowed only if they:

- Reflect a measurable decrease in market value due to the condition or age of the vehicle,\(^ {123}\) and
- Apply to parts normally subject to replacement and repair during the vehicle’s life, such as tires and batteries.\(^ {124}\)

(b) Salvage Value Adjustments — When Allowed

If the *first party* or *third party claimant* elects to keep the vehicle, the salvage value may be deducted from the settlement, and the settlement value of the sales tax associated with the cost of a comparable vehicle may be discounted by the amount of sales tax attributed to the salvage value of the lost vehicle. The settlement amount must, however, include all fees incident to transfer of the claimant’s vehicle to salvage status.\(^ {125}\)

The deductible salvage value is determined by the amount that would be paid for the vehicle by a salvage pool or licensed salvage dealer, wholesale auction or dismantler. The *insurer* must give the claimant written notice of DMV requirements regarding vehicle salvage retention.

5) Storage Charges — Termination, Retrieval of Vehicle

Before terminating payment for storage charges, an *insurer* must provide the claimant reasonable notice to allow the claimant time to remove the vehicle.\(^ {126}\)

6) Towing Expenses

The *insurer* must pay claimant’s reasonable towing and storage charges when the claim is a covered loss under a collision or comprehensive automobile *policy*, and towing and storage are reasonably necessary to protect the vehicle from further loss.\(^ {127}\)

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\(^{122}\) Regs., § 2695.8, subd. (j).

\(^{123}\) Regs., § 2695.8, subd. (i)(1).

\(^{124}\) Regs., § 2695.8, subd. (i)(2).

\(^{125}\) Regs., § 2695.8, subd. (b)(1)(A).

\(^{126}\) Regs., § 2695.8, subd. (k).

\(^{127}\) Regs., § 2695.8, subd. (k).
2. Settlement Standards for Fire and Extended Coverages

The following requirements are imposed for the adjustment and settlement of first party claims under fire and extended coverage policies providing for replacement cost.

a. Allocation of Consequential Damage Resulting From Repair or Replacement

When repair or replacement of an item or part is required, any consequential damage sustained in effecting repair or replacement not excluded by the insurance policy must be included in the loss, and the claimant may not be assessed for depreciation or any other charges, save the deductible.\(^{128}\)

b. Uniform Appearance Required for Replacement Articles

When replacement of items not matching in quality, color, or size is mandated, the insurer must replace all items in the damaged area so as to accomplish a reasonably uniform appearance.\(^{129}\)

c. Repair Referrals and Estimates

An insurer may not require the claimant to use a specific individual or entity to perform repairs but, upon the claimant’s request, may suggest a recommended provider.\(^{130}\) An insurer may also refer a claimant to a specific individual or entity for repairs if the claimant has been informed in writing of his or her right to select a repairer; however, if the claimant acts on the referral, the insurer must cause the damaged property to be restored to its prior condition and repaired using accepted trade standards at no additional cost to the claimant other than as stated in the policy or otherwise allowed under the regulations.\(^{131}\)

When obtaining repair estimates to be used as the basis for determining a settlement amount, the insurer must take reasonable steps to verify that the cost estimates are accurate and representative of costs in the local market area.\(^{132}\) The claimant must be provided a copy of the

\(^{128}\)Regs., § 2695.9, subd. (a)(1).
\(^{129}\)Regs., § 2695.9, subd. (a)(2).
\(^{130}\)Regs., § 2695.9, subd.(b).
\(^{131}\)Regs., § 2695.9, subd.(c)(1) and (2).
\(^{132}\)Regs., § 2695.9, subd.(d).
estimate and any other documents providing the basis for the insurer’s proposed settlement amount. If the claimant obtains a higher repair estimate, the insurer must:

- Pay the difference between its estimate and the one obtained by the claimant;
- If requested by the claimant, provide the name of at least one individual or entity that will make the repairs for the amount of insurer’s written estimate and then ensure that the recommended individual or entity restores the damaged property to its prior condition and conducts repairs using accepted trade standards at no additional cost to the claimant other than as stated in the policy or otherwise allowed under the regulations; or
- Make reasonable adjustments to the estimate prepared by the claimant’s choice of repair individual or entity and provide the claimant a copy of the adjusted estimate.\(^{133}\)

d. Appraisal

When the appraisal provision of the policy is invoked, the appraisal process is conducted using only those legal proceedings or procedures specified in Insurance Code section 2071. The parties may, however, pursue legal action on issues unrelated to appraisal, such as a declaratory relief action on coverage issues.\(^{134}\)

e. Rules for Deduction Based Upon Betterment, Depreciation, or Salvage

Deductions for betterment or depreciation must be justified by explicit and itemized documentation in the claim file, specified as to dollar amount, and must be an accurate reflection of the value of the reductions. The basis for the taking of betterment or depreciation deductions must be completely explained to the claimant in writing and a copy of the explanation must be retained in the claim file.\(^{135}\) The expense of labor necessary to repair, rebuild, or replace covered property is not a component of physical depreciation and may not be included in any adjustments for depreciation or betterment.\(^{136}\)

\(^{133}\) Regs., § 2695.9, subd.(d)(1) – (3).
\(^{134}\) Regs., § 2695.9, subd.(e).
\(^{135}\) Regs., § 2695.9, subd.(f).
\(^{136}\) Regs., § 2695.9, subd.(f) (1).
3. Settlement Standards for Surety

Regulations addressing settlement standards applicable to surety insurance \(^{137}\) are discussed in Part Two of this handbook, “Surety.”

4. Settlement Standards for Life and Disability Claims

a. Withholding of Benefits Based Upon Overpayment

Benefits may not be withheld on the basis that an overpayment on a prior claim against the same insurance policy has been made unless: \(^{138}\)

- The claim file contains clear evidence of overpayment plus written authorization from the claimant or his or her assignee consenting to the withholding; \(^{139}\) or
- There is no reasonable dispute as to the facts surrounding the overpayment \(^{140}\) and the claim file clearly documents each of the following:
  - The overpayment was clearly erroneous pursuant to the insurance policy’s provisions; \(^{141}\)
  - The overpayment did not result from an error constituting mistake of law; \(^{142}\)
  - The claimant receives notification within six months of the date of error. However, where the overpayment results from error caused by representations or nondisclosure of either the claimant or a third party, the insurer must notify the claimant within 15 days from the discovery of the error. The date of the error is the date of issuance of the draft for benefits; \(^{143}\)
  - The notice states both the cause of error and the amount of overpayment. \(^{144}\)

\(^{137}\) Regs., § 2695.10, subd. (a-g).
\(^{138}\) Regs., § 2695.11, subd. (a).
\(^{139}\) Regs., § 2695.11, subd. (a)(1).
\(^{140}\) Regs., § 2695.11, subd. (a)(2) and § 2695.11 subd. (a)(2)(E).
\(^{141}\) Regs., § 2695.11, subd. (a)(2)(A).
\(^{142}\) Regs., § 2695.11, subd. (a)(2)(B).
\(^{143}\) Regs., § 2695.11, subd. (a)(2)(C).
\(^{144}\) Regs., § 2695.11, subd. (a)(2)(D).
b. Explanation of Benefits Required

An explanation of benefits that includes the name of the provider or services covered, dates of service, and understandable explanation of how the benefits were computed must accompany each claim payment to a claimant or his or her assignee.\(^\text{145}\)

c. Pre-Certification Requirements Penalties

Insurers are forbidden to impose penalties for noncompliance with benefits pre-certification requirements unless the penalties are specified and clear in the insurance policy or certificate.\(^\text{146}\)

G. Penalties

A complete discussion of penalties and available relief is set forth in Part Three of this handbook, “Fair Claims Handling Investigations and Subsequent Proceedings.” The following provides an overview.

1. Criteria for Assessing Penalties

The Commissioner considers the following factors when determining whether a violation of the regulations occurred warranting the assessment of penalties:

- The existence of extraordinary circumstances;\(^\text{147}\)
- The existence of a good faith, reasonable basis to believe the claim is fraudulent or otherwise illegal and the licensee has complied with the applicable provisions of the Insurance Code;\(^\text{148}\)
- The complexity of the claim;\(^\text{149}\)
- Whether the value of the property or severity of the injury was grossly exaggerated;\(^\text{150}\)
- Whether the facts of the loss were substantially mischaracterized;\(^\text{151}\)
- Whether property claimed as lost or destroyed was secreted.\(^\text{152}\)

\(^{145}\)Regs., § 2695.11, subd. (b).
\(^{146}\)Regs., § 2695.11, subd. (c).
\(^{147}\)Regs., § 2695.12, subd. (a)(1). Regs., § 2695.2, subd. (e) defines such circumstances as those outside the control of the licensee that severely and materially affect its ability to conduct normal business operations.
\(^{148}\)Regs., § 2695.12, subd. (a)(2), and see Ins. Code § 1872.4.
\(^{149}\)Regs., § 2695.12, subd. (a)(3).
\(^{150}\)Regs., § 2695.12, subd. (a)(4).
\(^{151}\)Regs., § 2695.12, subd. (a)(5).
\(^{152}\)Regs., § 2695.12, subd. (a)(6).
Part One
Summary of Fair Claims Settlement Practices Regulations

• The proportion of claims in which noncompliance was found to the total number of claims handled by the licensee and the total number of claims reviewed by the Commissioner during the time period in question;\textsuperscript{153}
• Whether remedial measures\textsuperscript{154} have been taken;\textsuperscript{155}
• The licensee’s previous record as to violations;\textsuperscript{156}
• The degree of harm caused by the noncompliance;\textsuperscript{157}
• Whether the licensee made a good faith attempt at compliance;\textsuperscript{158}
• The frequency of occurrence and/or severity of harm to the public caused by the violation,\textsuperscript{159}
• Whether the licensee’s management was aware of facts that apprised or should have apprised the licensee of the act and the licensee failed to take remedial measures;\textsuperscript{160} and
• The licensee’s reasonable mistakes or opinions as to valuation of property, losses, or damages.\textsuperscript{161}

2. Range of Penalties

A licensee violating any regulation is subject to all available monetary penalties and administrative actions within the jurisdiction of the Commissioner, up to and including suspension or revocation of an insurer’s certificate of authority or license or revocation or suspension of an agent’s license.

\textsuperscript{153}Regs., § 2695.12, subd. (a)(7).
\textsuperscript{154}The regulations define “remedial measures” as “those actions taken by an insurer to correct or cure any error or omission in the handling of claims on the part of its insurance agent…” Regs., §2695.2, subd. (f).
\textsuperscript{155}Regs., § 2695.12, subd. (a)(8).
\textsuperscript{156}Regs., § 2695.12, subd. (a)(9).
\textsuperscript{157}Regs., § 2695.12, subd. (a)(10).
\textsuperscript{158}Regs., § 2695.12, subd. (a)(11).
\textsuperscript{159}Regs., § 2695.12, subd. (a)(12).
\textsuperscript{160}Regs., § 2695.12, subd. (a)(13).
\textsuperscript{161}Regs., § 2695.12, subd. (a)(14).
H. Compliance Date

A new section was added to the regulations with the 2006 amendments.\textsuperscript{162} It provides that any amendments to the regulations shall be complied with within 90 days after the amendments are filed with the Secretary of State.\textsuperscript{163} Thus, amendments were on June 1, 2006, had a compliance date of August 31, 2006.

Of particular import, the regulations apply to any claims handling that takes place on or after the compliance date.\textsuperscript{164} Therefore, if the amendments call for actions not previously called for, such as notice, insurers arguably must provide these notices to existing claimants, whose claims are currently under investigation.

\textsuperscript{162} Regs., § 2695.14.
\textsuperscript{163} Regs., § 2695.14, subd. (a).
\textsuperscript{164} Regs., § 2695.14, subd. (c).
## I. Chart for Time Limits/Diarying Requirements

### 1. Time Limits Regarding Communications From Claimants

<table>
<thead>
<tr>
<th>TIME LIMITS</th>
<th>ACTION REQUIRED</th>
<th>CITATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within 15 calendar days after receiving notice of claim that is not notice of legal action</td>
<td>Acknowledge receipt of the notice of claim and begin any necessary investigation of the claim and provide the claimant with necessary claim forms, instructions, and reasonable assistance.</td>
<td>§2695.5(e)(1-3)</td>
</tr>
<tr>
<td>Within 15 calendar days after receiving any communication indicating response is required</td>
<td>Reply to any communication from a claimant regarding a claim that reasonably suggests a response is requested. This period does not apply where a legal action has been initiated.</td>
<td>§2695.5(b)</td>
</tr>
<tr>
<td>Within 40 calendar days after receipt of proof of claim</td>
<td>Accept or reject the claim, in whole or in part, and affirm or deny liability.</td>
<td>§2695.7(b)</td>
</tr>
<tr>
<td>Every 30 days beginning within initial 40-day period</td>
<td>Notify claimant of insurer's inability to make determination regarding acceptance or settlement and why.</td>
<td>§2695.7(c)(1)</td>
</tr>
<tr>
<td>For unrepresented claimants, at least 60 days before expiration of the statute of limitations or other time period limitation requirement applicable to the claim, or immediately if a claim is received within 60 days of an expiring statute or other time limit; or, 30 days prior to the expiration of an uninsured motorist claim statute, or immediately if the claim is received within 30 days of an expiring uninsured motorist statute</td>
<td>Notify the claimant of the statute of limitations or other time limitation in writing.</td>
<td>§2695.7(f)</td>
</tr>
</tbody>
</table>

The regulations define “calendar days” as “each and every day including Saturdays, Sundays, Federal and California State Holidays, but if the last day for performance of any act required by these Regulations falls on a Saturday, Sunday, Federal or State Holiday, then the period of time to perform the act is extended to and including the next calendar day which is not a Saturday, Sunday, or Federal or State holiday.” Regs., § 2695.2, subd. (b).
2. Time Limits Regarding Settlement Payments

<table>
<thead>
<tr>
<th>TIME LIMITS</th>
<th>ACTION REQUIRED</th>
<th>CITATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediately or within 30 calendar days after acceptance of a claim and receipt of a release when necessary</td>
<td>Tender payment of undisputed amount of claim. Exceptions apply where multiple coverages are applicable and insured’s interests would be impaired.</td>
<td>§2695.7(h)</td>
</tr>
</tbody>
</table>

3. Time Limits Regarding Commissioner Communications, Training and Certification

<table>
<thead>
<tr>
<th>TIME LIMITS</th>
<th>ACTION REQUIRED</th>
<th>CITATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>21 calendar days of receipt of inquiry regarding claim from Department of Insurance (DOI)</td>
<td>Furnish DOI with written response to inquiry.</td>
<td>§2695.5(a)</td>
</tr>
<tr>
<td>September 1 each year</td>
<td>Certification under penalty of perjury by principal of licensee that (1) claims adjusting manual contains a copy of the regulations and all amendments, (2) clear written instructions regarding proper compliance with regulations have been provided to all employees who have involvement in claims handling, and (3) if independent adjusters used, training has been provided to them or they have themselves certified they have received training.</td>
<td>§2695.6(b)(5)</td>
</tr>
<tr>
<td>December 1, 2006</td>
<td>Adopt and communicate to claims agents written standards for the prompt investigation and processing of claims.</td>
<td>§2695.6(a)</td>
</tr>
</tbody>
</table>
Part Two
Surety

A. Introduction

The regulations, when first promulgated, recognized that "surety insurance" is different than other lines of insurance. The regulations previously stated:

These regulations recognize the unique relationship which exists under a surety bond between the insurer, the obligee or beneficiary, and the principal. In contrast to other classes of insurance, surety insurance involves a promise to answer to the debt, default or miscarriage of a principal who has the primary duty to pay the debt or discharge the obligation and who is bound to indemnify the insurer. Therefore, only sections 2695.1 through 2695.6, inclusive section 2695.10, and sections 2695.12, 2695.13 and 2695.14, inclusive, shall apply to the handling or settlement of claims brought under surety bonds.

The California Supreme Court quoted the above language in issuing its opinion that sureties should not be subject to tort liability under a cause of action for a breach of the implied covenant of good faith and fair dealing in the same fashion as traditional insurance carriers.

The 2006 amendments changed the above statement to the following:

In recognition of both the unique relationship which exists under a surety bond between the surety, the obligee or beneficiary, and the principal, and the fact that the processing of surety claims is subject to the Unfair Practices Act, beginning with California Insurance Code Section 790, only sections 2695.1 through 2695.6, inclusive, section 2695.10, and sections 2695.12, 2695.13 and 2695.14, inclusive, shall apply to the handling or settlement of claims brought under surety bonds.

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166 Surety is referred to as "surety insurance" throughout the regulations and in the California Insurance Code.
167 The regulations define "obligee" as "the person named as obligee in a bond." Regs., §2695.2, subd. (p).
168 Former Regs., §2695.1, subd. (c).
170 Regs., §2695.1, subd. (c).
Accordingly, sureties are bound only by the following sections of the regulations:

- Section 2695.1 - Preamble
- Section 2695.2 - Definitions
- Section 2695.3 - File and Record Documentation
- Section 2695.4 - Representation of Policy Provisions and Benefits
- Section 2695.5 - Duties Upon Receipt of Communications
- Section 2695.6 - Training and Certification
- Section 2695.10 - Standards Applicable to Surety Insurance
- Section 2695.12 - Noncompliance and Penalties
- Section 2695.13 - Severability
- Section 2695.14 - Effective Dates

Thus, in understanding the surety’s duties under the regulations, it is important to first review the portions of this handbook concerning the other sections applicable to insurers, licensees, and sureties, particularly those concerning file and record documentation (section 2695.3), representation of insurance policy and bond provisions and benefits (section 2695.4), duties upon receipt of communications (section 2695.5), training and certification (section 2695.6), and noncompliance and penalties (section 2695.12).

DO NOT RELY ON THIS DISCUSSION ALONE TO UNDERSTAND ALL OF THE REQUIREMENTS IMPOSED UPON SURETIES.

B. Claims Handling and Settlement Duties of Sureties

Apart from describing surety bond or bond as “the written instrument in which a contract of surety insurance is set forth,” the regulations do not define the term “surety insurance.” Consequently, the regulations do not expressly indicate whether fidelity bonds are included within the ambit of the regulations pertaining to “surety insurance.”

Because the source of the Commissioner’s powers to regulate claims settlement practices is conferred by the Insurance Code, to resolve the issue of whether fidelity bonds are

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171 Regs., § 2695.2, subd. (w).
172 The only definition provided in the regulations is for “surety bond” or “bond.” Under the regulations, (Regs., § 2695.2, subd. (w)) “surety bond” or “bond” is defined as the “the written instrument in which a contract of surety insurance is set forth.”
173 Ins. Code, §§ 790 et seq.
included within the definition of *surety bonds* or *bonds*, the Insurance Code should provide
guidance. Insurance Code section 105 defines “surety insurance” to include “the guarantee-
ing of behavior of persons” and “insurance against loss resulting from the forgery or altera-
tion of any instrument of any kind or character or of any signature thereon.” Accordingly,
fidelity bonds, which provide indemnity for loss caused by fraudulent or dishonest acts of
employees, would arguably fall within the definition of “surety insurance” in the regulations.
Therefore, there exists a strong argument that fidelity insurers would be governed under
the special section of the regulations applicable to surety insurers. Nonetheless, historically,
fidelity insurers have considered themselves more closely akin to insurance than surety in
connection with their claims handling and their exposure to bad faith claims, in contrast to
surety companies. Also, the nature of the 2006 amendments applicable to surety suggest
that the drafters of the amendments intended those regulations to apply to sureties and not
fidelity insurers. In any event, other than the disclosure requirements, there is now rela-
tively little difference between those regulations governing surety and those governing most
of the other lines of commercial insurance.

1. Prohibited Claims Handling Conduct

  a. Discriminatory Claims Settlement Practices

Sureties, as all licensees, are prohibited from basing or varying claims settlement practices
or standards of scrutiny or claims review upon a claimant’s age, race, gender, income, re-
ligion, language, sexual orientation, ancestry, national origin, physical disability, or region.

  b. Generally Prohibited Acts

See discussion regarding Generally Prohibited Acts in Part One, B. Claims Handling Duties,

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174 Ins. Code § 105, subd. (a).
175 Ins. Code § 105, subd. (b).
176 Included are banker’s blanket bonds, savings and loan blanket bonds and comprehensive dishonesty
and destruction and disappearance bonds.
177 See, e.g., §§ 2695.10, subd. (b)(1) and (2).
178 “Claimant” is defined, in connection with surety insurance, as “any person who asserts a right of re-
covery under a surety bond” or any of the following representatives: attorney, insurance adjuster, public
adjuster, or a member of the claimant’s family. Regs., § 2695.2, subd. (c).
179 Regs., § 2695.10, subd. (a).
2. Basic Duties Regarding Claims Handling

Licensees, insurance agents and claims agents must immediately transmit notice of claims to the surety. Failure to do so is imputed to the surety. Upon receipt of a claim, a surety must diligently investigate the claim. A surety must provide the claimant with acknowledgment of receipt of the claim within 15 days of receiving the claim, unless payment is made within that 15-day period. A surety cannot persist in seeking information that is not reasonably required for settlement. Because the regulations provide that a surety cannot deny a claim on the basis of information received in the course of a telephone conversation unless the conversation is documented in the claims file, any communications with the claimant should be documented in the claims file. Under the regulations, a claims file should contain sufficient information regarding each claim so that pertinent events and dates can be reconstructed and the surety’s actions can be determined.

3. Statute of Limitations and Time Limit Disclosures

Unless represented by counsel, a surety must provide written notice of any statute of limitation or other time period requirement upon which the surety may rely to deny a claim. The notice must be given no less than 60 days prior to the expiration date. Failure to provide such notice may result in a tolling of the statute of limitation. There is no time limit in the regulations as to how soon prior to the expiration date the surety can give the notice. Accordingly, a surety arguably may give the notice the first time it communicates with the claimant. Appendix D contains sample notices for the most common forms of surety bonds in California.

If the claim notice is first received within the final 60 days that a claim may be timely brought, the surety must provide the notice immediately.

The regulations simply require that the surety give notice of any statute of limitation or other

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180 Regs., § 2695.5, subd. (d).
181 Regs., § 2695.5, subd. (e)(1).
182 Regs., § 2695.10, subd. (d).
183 Regs., § 2695.5, subd. (e)(1).
184 Regs., § 2695.10, subd. (d).
185 Regs., § 2695.10, subd. (e).
186 As discussed above, claims files are subject to inspection by the Commissioner to determine whether unfair claims practices have occurred. However, the Commissioner need not be provided with privileged documents.
187 Regs., § 2695.3.
188 Regs., § 2695.10, subd. (g).
189 See Spray, Gould & Bowers v. Associated Internat Ins. Co., 71 Cal. App. 4th 1260, 84 Cal. Rptr. 2d 552 (1999) (Insurer could be equitably estopped from asserting contractual limitations period based on failure to provide notice claimant regarding same pursuant to regulations).
190 Id.
time period requirement. They do not require the surety to determine the expiration date except to the extent it affects when the surety gives notice. They also do not require the surety to give notice of that expiration date, only the statute or the time period requirement.

Arguably, this requirement applies to any claims handling that occurs on or after August 31, 2006. Accordingly, sureties should provide such notices to all claimants with pending claims, regardless of the status of the surety’s investigation.

4. Acceptance or Denial of Claims

a. Notification of Acceptance or Denial

Where a claim is not in litigation or arbitration, and a claim on a surety bond is made, the surety must give written notification of the acceptance or denial (in whole or in part) of a claim as soon as possible but, in no event, later than 40 days after receipt of the proof of claim. This requirement is imposed both for total and partial denials or rejections.

The written notification of the surety’s denial or rejection of a claim must provide to the claimant a statement listing all of the bases for rejection and the factual and legal bases for each reason. If the surety’s denial is based on a statute or bond provision, the denial must reference the statute or bond provision and provide an explanation.

The written notification to the claimant that the surety denies or rejects a claim, or disputes liability or damages, must include a statement that the claimant may have the matter reviewed by the California Department of Insurance, and must provide the address and telephone number of the unit of the department that reviews complaints regarding claims practices.

That address and telephone number is:

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191 Regs., § 2695.14, subd. (c).
192 Regs., § 2695.10, subd. (b).
193 Regs., § 2695.10, subd. (b).
194 Regs., § 2695.10, subd. (b).
195 Id.
196 Regs., § 2695.10, subd. (b).
b. Extensions of Time Within Which to Accept or Deny Claims

Where there is a reasonable need for an extension of time to accept or deny a claim (in whole or in part) because the surety does not have sufficient information to make a decision, a surety may obtain a 30-day extension of the period to accept or deny the claim, in whole or in part.\(^{197}\) To extend the time period, within 30 days (unless there are extraordinary circumstances\(^{198}\) and then within 40 days) from the initial notice of claim, the surety must notify the claimant of the need for an extension.\(^{199}\) The notice must specify the reasons for the need for additional time and any additional information the surety requires in order to make a determination. The 30-day extension can be repeated in 30-day increments if the claimant is given notice every 30 days (until notice of legal action is received).

If the reason the surety cannot make a determination in response to the claim is because the claimant has failed to respond to requests for additional information, the surety arguably has several options to respond to the claim, none of which are articulated in the regulations:

- The surety can continue to provide the 30-day notices indefinitely;
- The surety can advise the claimant that, because the claimant has not provided sufficient documentation to support its claim, the surety assumes that the claimant has withdrawn its claim and that the surety will close its claim file, which will be reopened if the claimant does provide sufficient documentation to support its claim. (This option assumes that the surety is unable to obtain documentation concerning the claim from other sources, such as its bond principal); and
- The surety can deny the claim based on the claimant’s failure to provide sufficient

\(^{197}\) Regs., § 2695.10, subd. (c).

\(^{198}\) The regulations define “extraordinary circumstances” as “circumstances outside of the control of the licensee which severely and materially affect the licensee’s ability to conduct normal business operations.”

\(^{199}\) Regs., § 2695.10, subd. (c).
documentation to support its claim. (Again, this option assumes that the surety is unable to obtain documentation concerning the claim from other sources.) This option requires the statement that the claimant may have the matter reviewed by the Department of Insurance.

If the surety cannot make a determination until “some event, process, or third-party determination” has occurred, the surety can extend the 40-day period indefinitely provided the surety specifies the event, process or third-party determination and gives the claimant an estimate as to when the determination can be made. The regulations are silent as to what constitutes an event, process, or third party determination. Some possibilities might include the completion of an arbitration between the claimant and the principal or the completion of a criminal trial of a fidelity bond principal.

c. Bond Principal’s Input in Claim Handling

A principal’s absence, non-cooperation, or failure to meet the bonded obligation cannot be the basis for a surety to unreasonably delay in determining whether it should accept or deny a claim.

In addition, a surety may not deny a claim absent reasonable factual and legal bases for same, based solely on the principal’s protest of a claim or denial of liability, although a surety may consider all information that the principal provides to the surety.

d. Payment of Claims

If an undisputed claim is to be paid, with no release required, the surety must tender the payment within 15 calendar days following affirmation of liability. Where a release is required, the surety must provide the release to the claimant within 10 calendar days following affirmation of liability, and must pay the claim 15 calendar days following the surety’s receipt of a fully executed release.

Where multiple claimants are involved, the surety must make payment pursuant to the time

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200 The regulations state only that the claimant must be advised of the situation (Regs., § 2695.10, subd. (c)), but a prudent surety should specify the situation in reasonable detail.
201 Regs., § 2695.10, subd. (b)(1).
202 Regs., § 2695.10, subd. (b)(2).
203 Regs., § 2695.10, subd. (f).
204 Regs., § 2695.10, subd. (f).
limits above except that the surety does not need to comply with the time limits if the payment would increase the surety’s liability or impair the rights of other claimants under the bond.

C. Commissioner’s Determination of Unfair Claims Practices by Surety

1. Factors Used to Determine Whether Unfair Claims Practices Occurred

Sureties are prohibited from attempting to settle a claim by making a settlement offer that is unreasonably low.205

The Commissioner is to consider the following factors in determining whether a surety has made an unreasonably low settlement offer:

- The extent to which the surety considered evidence that the claimant submitted to support the value of the claim;
- The extent to which the surety considered legal authority or evidence;
- The procedures that the surety used in determining the amount of damages; and
- Other credible evidence that demonstrates the final amount that the surety offered to settle the claim was below the amount that a reasonable person would offer to settle the claim.

D. Chart for Time Limits/Diarying Requirements

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205 Regs., § 2695.10, subd. (h).
1. Time Limits Regarding Communications From Claimants

2. Time Limits Regarding Settlement Payments

<table>
<thead>
<tr>
<th>TIME LIMITS</th>
<th>ACTION REQUIRED</th>
<th>CITATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 calendar days upon receiving notice of claim</td>
<td>Acknowledge receipt of the notice of claim, provide claim forms, and begin any necessary investigation of the claim.</td>
<td>§2695.5(e)</td>
</tr>
<tr>
<td>40 calendar days after receipt of proof of claim</td>
<td>Accept or deny the claim, in whole or in part, and affirm or deny liability, in writing, with notification that claimant can have matter reviewed by Department of Insurance, if claim or liability denied.</td>
<td>§2695.10(b)</td>
</tr>
<tr>
<td>30 calendar days of receipt of proof of claim (unless extraordinary circumstances, then 40 days)</td>
<td>Provide claimant written notice of the need for additional time to determine whether to accept or deny claim, and why.</td>
<td>§2695.10(c)</td>
</tr>
<tr>
<td>Every 30 calendar days after the first notice that surety needs additional time</td>
<td>Provide claimant written notice of the continuing need for additional time to determine whether to accept or deny claim, and why.</td>
<td>§2695.10(c)</td>
</tr>
<tr>
<td>15 calendar days after receipt of communication from claimant regarding claim suggesting response expected</td>
<td>Reply</td>
<td>§2695.5(b)</td>
</tr>
<tr>
<td>For unrepresented claimants, at least 60 days before expiration of statute of limitations or other time period limitations applicable to the claim, or immediately if a claim is received within 60 days of an expiring statute of limitation or other time limit</td>
<td>Notify claimant in writing of the statute of limitation or other time period upon which surety may rely to deny claim.</td>
<td>§2695.10(g)</td>
</tr>
</tbody>
</table>

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206 This time limit does not apply where the notice of claim is a notice of legal action. Regs., § 2695.5, subd. (b).

207 This time limit is not applicable subsequent to receipt by the surety of notice of legal action by claimant. Regs., § 2695, subd. (b).
### 3. Time Limits Regarding Commissioner Communications, Training, and Certification

<table>
<thead>
<tr>
<th>TIME LIMITS</th>
<th>ACTION REQUIRED</th>
<th>CITATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 calendar days following affirmation of liability, where no dispute regarding claim or amount</td>
<td>Provide release to claimant.</td>
<td>§2695.10(f)</td>
</tr>
<tr>
<td>15 calendar days following surety's receipt of signed release</td>
<td>Tender payment to claimant.</td>
<td>§2695.10(f)</td>
</tr>
<tr>
<td>15 calendar days following affirmation of liability, where no dispute regarding claim or amount</td>
<td>Tender payment to claimant, if no release is required by surety.</td>
<td>§2695.10(f)</td>
</tr>
<tr>
<td>TIME LIMITS</td>
<td>ACTION REQUIRED</td>
<td>CITATION</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>21 calendar days of receipt of inquiry regarding claim from DOI</td>
<td>Furnish DOI with written response to inquiry.</td>
<td>§2695.5(a)</td>
</tr>
<tr>
<td>September 1 each year</td>
<td>Certification under penalty of perjury by principal of licensee that (1) claims adjusting manual contains a copy of the regulations and all amendments, (2) clear written instructions regarding proper compliance with regulations have been provided to all employees who have involvement in claims handling, and (3) if independent adjusters used, training has been provided to them or they have themselves certified they have received training.</td>
<td>§2695.6(b)(5)</td>
</tr>
<tr>
<td>December 1, 2006</td>
<td>Adopt and communicate to claims agents written standards for the prompt investigation and processing of claims.</td>
<td>§2695.6(a)</td>
</tr>
</tbody>
</table>
Part Three
Fair Claims Handling Investigations and Subsequent Proceedings

A. Investigation and Prosecution of Unfair Claims Practices

1. Investigations by Commissioner

Insurance Code section 790.04 authorizes the Commissioner to investigate the claims handling practices of licensees. Because they do not meet the definition of licensees, non-admitted insurers will not be subject to administrative proceedings, but admitted insurers, surplus lines brokers, and any person holding a certificate of authority for the transaction of insurance business within California are subject to administrative investigation and prosecution for unfair claims practices.

The regulations permit the Commissioner to inspect a licensee’s claims files without first initiating administrative proceedings. The regulations provide that the licensee must make available claims files containing “documents, notes, and work papers (including copies of all correspondence) which reasonably pertain to each claim in such detail that pertinent events and the dates of the events can be reconstructed and the licensee’s actions pertaining to the claim can be determined.”

The regulations do not speak to whether the licensee must make available for the Commissioner’s inspection privileged materials contained in claims files, such as attorney-client communications as to coverage issues or litigation questions (including recommendations regarding settlement), or attorney work-product protected documents. However, California law does not allow a state agency to compel the disclosure of materials protected by the attorney-client privilege or the work-product doctrine. Consequently, a licensee need not produce materials protected by the attorney-client privilege or the work-product doctrine to the Commissioner. However, an insurer may disclose information pertaining to individual insureds to the Commissioner without violating the California Insurance Privacy Protection Act.

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208 Regs., § 2695.3, subd. (a) (inspection); § 2695.12 (penalties).
209 Regs., § 2695.2, subd. (m) (licensee); § 2695.2, subd. (i) (insurer).
210 Regs., § 2695.3, subd. (a); § 2695.5, subd. (a).
211 Regs., § 2695.3.
212 Government Code § 11507.6, subd. (f). Moreover, to the extent any order or regulation of the Commissioner contravenes existing law, such order is void. Morris v. Williams, 67 Cal.2d 733, 748, 63 Cal. Rptr. 689 (1967); Calif. Welfare Rights Organization v. Carleson, 4 Cal.3d 445, 455, 93 Cal.Rptr. 758 (1971); Harris v. Alcoholic Beverage Control App. Bd., 228 Cal.App.2d 1, 39 Cal.Rptr. 192 (1964).
213 The California Insurance Privacy Protection Act authorizes disclosure to “an insurance regulatory authority,” and to the extent required by law. Ins. Code § 791.13, subds. (e), (f), (g).
Beyond the inspection of claims files, the Commissioner is authorized to initiate administrative proceedings to investigate the claims handling practices of licensees. Further, hearings on claims investigations may be conducted pursuant to the California Administrative Procedure Act.\textsuperscript{214}

In conducting an investigation of claims handling practices, the Commissioner may subpoena documents in the possession of the insurer. However, because the regulations provide that a licensee’s records are available for inspection by the Commissioner without an administrative proceeding, the subpoena power was probably intended to reach documents in the possession of persons other than a licensee.\textsuperscript{215} As long as the matter is within the Commissioner’s jurisdiction, no demonstration of good cause or relevancy is necessary for the Commissioner to issue a subpoena.\textsuperscript{216} The Commissioner’s subpoena may be enforced or challenged in superior court, but a subpoena is valid as long as it relates to a matter within the Commissioner’s jurisdiction.

2. Administrative Proceedings to Enforce Violations of Unfair Claims Practices Regulations

The Commissioner generally enforces the fair claims handling regulations by conducting administrative hearings. According to the regulations, the Commissioner is to conduct the investigation and prosecution of unfair claims handling practices according to the Administrative Practices Act (Government Code sections 11500-11523). The regulations contemplate that administrative hearings will be held for two general purposes. First, the Commissioner is authorized to seek orders enjoining unfair claims practices and/or imposing penalties for violations.\textsuperscript{217} Second, the Commissioner may seek, for a subsequent violation of any order, the suspension or revocation of the licensee’s license to transact insurance business for a period not to exceed one year.\textsuperscript{218}

a. Initiation of Order to Show Cause Proceedings

After conducting its investigation and determining that it would serve the public interest, the Commissioner is authorized to initiate penalty proceedings with respect to any unfair claims

\textsuperscript{214} Ins. Code § 790.05.
\textsuperscript{215} Regs., § 2695.3.
\textsuperscript{217} Ins. Code § 790.07.
\textsuperscript{218} Id.
practice, whether specified in Insurance Code section 790.03, subdivision (h). The Commissioner initiates penalty proceedings by issuing and serving an order to show cause, which must contain a statement of charges, the potential liability claimed, and a notice of the date, time, and place of hearing. The notice must provide at least 30 days advance notice of the hearing.

For unintentional violations, the Commissioner may seek monetary penalties not to exceed $5,000, and the issuance of a cease and desist order. If the act or practice is willful, the Commissioner may seek a penalty not to exceed $10,000 for each act amounting to an unfair claims practice. Although the Commissioner is given the authority to determine what constitutes an act of unfair claims practice, when the “issuance, amendment, or servicing of a policy is inadvertent, all of those acts shall be a single act.” The definition of a “single act” under the regulations is “any commission or omission which in and of itself constitutes a violation of the California Insurance Code Section 790.03 or this subchapter.”

b. Initiation of Penalty Order Violation Hearings

If the licensee fails to comply with an order requiring the cessation of an unfair claims handling practice, the Commissioner has the option of seeking either: (1) the imposition of additional monetary penalties, or (2) the suspension or revocation of the license to transact insurance business.

If the Commissioner seeks only the imposition of an additional penalty, the regulations do not clearly specify the procedure for commencing the hearing process. In any event, an additional hearing is required, and such hearing must be conducted in accordance with the Administrative Procedure Act.

219 Ins. Code § 790.06, subd. (a).
220 Ins. Code § 790.05 provides, in relevant part, as follows: “Whenever the Commissioner shall have reason to believe that a person has been engaged or is engaging in this state in any unfair...practice defined in Section 790.03, and that a proceeding by the Commissioner...would be to the interest of public, [the Commissioner] shall issue and serve upon that person an order to show cause....”
221 Ins. Code § 790.05.
222 Id.
223 Ins. Code §§ 790.035 and 790.05.
224 The regulations define “willful” as “applied to the intent with which an act is done or omitted means simply a purpose or willingness to commit the act, or make the omission.... It does not require any intent to violate the law, or to injure another, or to acquire any advantage.” Regs., § 2695.2, subd. (y).
225 Ins. Code § 790.035, subd. (a).
226 Ins. Code § 790.035, subd. (a). The regulations define a “single act” as “any commission or omission which in and of itself constitutes a violation of California Insurance Code Section 790.03 or this subchapter.”
227 Regs., § 2695.2, subd. (v).
228 For example, Gov’t Code § 11503 provides for the filing of “accusations” in cases where suspension or revocation of licenses or rights is sought. Insurance Code section 790.06 provides for the issuance of orders to show cause where unfair claims practices are charges. There is no provision for pleadings merely seeking additional monetary penalties. Insurance Code section 790.07 provides for a hearing, but does not specify how such hearing is initiated. Presumably, minimum notice of the Commissioner’s intent to seek additional penalties is required.
229 Ins. Code § 790.07.
If the unfair claims practices that were ordered to cease nonetheless continue after the issuance of the order, the Commissioner may seek an additional $5,000 penalty for each unfair claims act that occurred after the issuance of the final penalty order.\(^\text{230}\) If a \textit{willful} violation of the order is demonstrated, the Commissioner may seek the imposition of an additional penalty of up to $55,000.\(^\text{231}\)

\subsection*{c. Initiation of License Suspension or Revocation Hearings}

Under the Administrative Practices Act, the Commissioner may file an “accusation” to initiate hearings to revoke, limit, or suspend a license.\(^\text{232}\) The accusation must contain a written statement of the charges in clear and concise language, and must specify the acts or omissions with which the \textit{licensee} is charged sufficiently to enable the \textit{licensee} to prepare a defense.\(^\text{233}\) The accusation need not be verified if it is signed by the Commissioner or by an employee of the Commissioner before the proceeding is to be held.\(^\text{234}\)

If the \textit{licensee} decides to contest the accusation, a responsive pleading, referred to as “a notice of defense,” must be filed within 15 days after service of the accusation. In the notice of defense, the \textit{licensee} may (1) request a hearing, (2) object to the accusation as being in excess of the Commissioner’s jurisdiction, or (3) argue that the accusation contains insufficient facts to allow the licensee to determine the transaction described in the accusation to prepare a defense.\(^\text{235}\) The notice of defense must be signed, but need not be verified.\(^\text{236}\)

Prior to the hearing, on motion of either party or on order of the administrative law judge, a pretrial conference may be held to determine any or all of the following: (1) whether settlement is possible; (2) whether any facts can be stipulated to; (3) the contested issues; (4) the order of presentation of evidence; and (5) whether it is necessary to issue rulings regarding the issuance of subpoenas and protective orders.\(^\text{237}\) Upon conclusion of the pretrial conference, the administrative judge must issue a pretrial conference order.\(^\text{238}\)

\begin{footnotes}
\item[230] Ins. Code §790.07.
\item[231] Id.
\item[232] Gov't Code § 11503.
\item[233] Id.
\item[234] Id.
\item[235] Gov't Code § 11506.
\item[236] Gov't Code § 11506, subd. (d).
\item[237] Gov't Code § 11511.5.
\item[238] Gov't Code § 11511.5, subd. (c).
\end{footnotes}
d. Initiation of Judicial Proceedings by Commissioner

If, after an administrative hearing in which a final order to cease unfair claims handling practices has been issued, a licensee does not discontinue the unfair claims practice found to exist at the penalty hearing, the Commissioner may, through the California Attorney General, file a petition in superior court seeking an injunction to restrain the unfair claims practice. The petition must contain a copy of the administrative hearing transcript, a copy of all evidence presented at the hearing, and a copy of the findings made by the Commissioner.

The superior court has the jurisdiction to make and enter appropriate orders, and to issue writs as the judge believes are necessary to prevent injury to the public. If the judge determines that unfair claims practices occurred, and that the findings made by the Commissioner are supported by the weight of the evidence, the superior court will issue an order enjoining and restraining the unfair claims practice.

If either the Commissioner or the licensee believes that new material evidence exists, an application may be made for leave to present the new evidence. The application must demonstrate there were reasonable grounds for the failure to present the evidence in the proceeding originally held by the Commissioner. In the event the application is granted by the superior court, the Commissioner has the right to modify the findings of fact, or make new findings.

3. Conduct of Administrative Proceedings

a. Hearing Judge

Every contested case is presided over by an administrative law judge, but the Commissioner has the right to insist that its designee hear the case with the administrative law judge. In such cases, the administrative law judge presides at the hearing, rules on the admission and exclusion of evidence, and advises the agency on matters of law, but the Commissioner’s office has the right to exercise all other powers relative to the hearing. The party subject to the hearing may submit an affidavit challenging the ability of the designee of

239 There is no language in the statute to the effect that the initiation of the petition proceeding in superior court is an alternative to administrative violation proceedings.
240 Ins. Code § 790.06, subd. (b).
241 Ins. Code § 790.06, subd. (c).
242 Ins. Code § 790.06, subd. (b).
243 Ins. Code § 790.06, subd. (d).
244 Ins. Code § 790.06, subd. (c).
245 Id.
246 Id.
247 Gov’t Code § 11512, subd. (a).
248 Id.
249 Gov’t Code § 11512, subd. (b).
250 Id.
the Commissioner to fairly and impartially hear the case, but the Commissioner’s office itself determines whether it is appropriate for its designee to preside over the hearing.

b. Discovery

After the initiation of an administrative proceeding, a party has the right to initiate discovery by service of a request for discovery within 30 days of service of the initial pleading filed by the agency, or within 15 days after the filing of a supplemental proceeding.251

The discovery request may request any of the following: a list of witnesses;252 written statements of any person named in the pleading;253 witness statements;254 and proposed documentary evidence255 on the agency’s investigative reports to the extent that such reports contain the names of witnesses or notes of the investigator’s perceptions.256 The Administrative Practices Act also provides for the taking of depositions and for the issuance of subpoenas to obtain information in the possession of third parties.257

A party cannot be compelled to disclose privileged information in discovery proceedings initiated pursuant to the California Administrative Practices Act.258 However, in certain situations, an “advice of counsel” defense to an alleged violation may constitute a waiver of privilege.259

In event of non-compliance with a discovery request, a petition to enforce discovery may be filed in superior court. The petition must demonstrate the reasons why such discovery is required, and the grounds for the refusal to produce the information.260

c. Admissibility of Evidence

Formal rules of evidence do not apply in administrative proceedings. Hearsay evidence may be admitted at the hearing, but only to supplement or explain other admissible evidence, and may not serve as the sole basis for an administrative determination.261

251 Gov’t Code § 11507.6.
252 Id.
253 Gov’t Code § 11507.6, subd. (a).
254 Gov’t Code § 11507.6, subd. (b).
255 Gov’t Code § 11507.6, subd. (d), (e).
256 Gov’t Code § 11507.6, subd. (f).
257 Gov’t Code § 11511.
258 Gov’t Code § 11507.6, subd. (f).
260 Gov’t Code § 11507.7.
261 Gov’t Code § 11513, subd. (c), (d).
d. Presentation of Witnesses

Testimony must be given under oath or affirmation. A party has the right to cross-examine any witness and present impeachment testimony.

e. Determinations and Orders

After a hearing, a written order must be issued, containing findings of fact, a determination of the issues presented, and the penalty, if any. Absent a stay, the decision becomes final 30 days after delivery to the licensee. A party may request reconsideration of the order before it becomes final.

B. Contesting Orders Issued by the Commissioner

1. Introduction

When an administrative hearing has been conducted by the Commissioner, questions arise as to what remedy a licensee may have to contest the resulting determinations or orders.

2. Judicial Review of Commissioner’s Determinations

a. Commencement of Proceedings to Review Determination

A party that contests an administrative determination may file a petition for writ of administrative mandamus in superior court within 30 days after the administrative decision becomes final. The ability to seek a writ is not affected by the failure to seek reconsideration of the administrative determination. Within 30 days after a writ petition has been filed, the agency will deliver a complete copy of the proceedings for the record, or the writ petition will be extended.

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262 Gov’t Code § 11513, subd. (a).
263 Gov’t Code § 11513, subd. (b).
264 If the case is heard by an administrative law judge alone, the proposed decision will be filed within 30 days. Gov’t Code § 11517, subd. (c)(3). Where the Commissioner determines to hear the proceeding, the administrative law judge prepares a proposed decision within the same time period as provided above, and the Commissioner must render a decision within 100 days of the submission of the case. Gov’t Code § 11517, subd. (d)(3).
265 Gov’t Code § 11517.
266 Gov’t Code § 11519, subd. (a).
267 Gov’t Code § 11521.
268 Code Civ. Proc. § 1094.5
269 Gov’t Code § 11523.
270 Id.
271 Id.
b. Scope of Review of Determinations

Because of the deference given by the courts to administrative discretion and expertise, before a writ commanding the Commissioner to change a determination can be issued, there must be a demonstration to the reviewing court that the administrative determination was deficient, either because procedural errors in the proceeding occurred that resulted in an adverse determination to the party seeking review, or the determination was not supported by the evidence presented in the course of the administrative proceeding.

A court will apply one of the following two tests in reviewing an administrative proceeding:

- Whether the administrative determination was supported by substantial evidence (the "substantial evidence" test); or
- Whether the determination is appropriate under an independent review of the evidence by the reviewing court (the "independent judgment" test).

Under the substantial evidence test, the reviewing court seeks to determine whether there is any substantial evidence, even if in conflict with other evidence, that supports the administrative determination. Under the independent judgment test, the reviewing court will independently review the evidence and make its own determination without regard to the determination by the administrative official.

Generally, because an administrative official is given "quasi-judicial" authority to investigate, hear evidence, and make findings on unfair claims handling practices, review of the administrative determination will be conducted according to the substantial evidence test. Although the issue of the Commissioner's powers has not yet been resolved by the courts, because of the quasi-judicial nature of the administrative hearings, it is probable the Commissioner will be held to have judicial powers in making determinations regarding unfair claims practices.

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273 Rule-making, or "quasi-legislative" action, involves the formulation of rules to be applied to all future cases. Strumsky v. San Diego County Employees Retirement Ass’n., 11 Cal.3d 28, 34-35, fn. 2, 11, 2 Cal.Rptr. 805 (1974). Adjudicative, or "quasi-judicial," acts involve the actual application of such rules to a specific set of existing facts. Id. The power to hear evidence and make findings is in contrast to the Commissioner’s powers to regulate insurance premium rates. Rate determinations have been held not to be the result of the exercise of judicial powers. California State Auto. Assn. Inter-Insurance Bureau v. Garamendi, 6 Cal.App.4th 1409, 8 Cal.Rptr.2d 366 (1992). In some circumstances, an administrative hearing may involve both legislative and adjudicative functions, depending on the questions the administrative agency is asked to resolve. Dominey v. Department of Personnel Administration, 205 Cal.App.3d 729, 738, 252 Cal.Rptr. 620 (1988).
C. Use of Commissioner Determinations in Subsequent Civil Litigation

Claimants’ attorneys are likely to attempt to obtain and utilize the Commissioner’s determinations in subsequent civil litigation involving the insurer, or they could attempt to obtain the determination either by subpoena or in a California Public Records Act request made to the Commissioner. Consequently, among the initial questions an insurer will face will be whether the Commissioner’s determinations are discoverable or independently obtainable. Assuming claimants’ attorneys have obtained the Commissioner’s determinations, questions will then arise as to whether the determinations are relevant, admissible, or have any probative value or preclusive effect.


Claimants may attempt to obtain the Commissioner’s determinations pursuant to the California Public Records Act, which enables members of the public to review and inspect information and documents in the possession of the government to ensure that the public interest is being served. The Public Records Act, however, exempts certain information and documents from disclosure when it would not serve the public interest because it would violate the right of privacy of or be detrimental to the person or entity described in the records, or to pending litigation involving the governmental agency. Privileged information is also not subject to disclosure.

The Public Records Act provides an exemption from disclosure for records obtained by a public agency for law enforcement or licensing purposes. However, it is not clear whether this exemption precludes disclosure of determinations by the Commissioner for two reasons. First, the Public Records Act does not preclude a state agency from voluntarily releasing information if it should elect to disclose the records. Second, the exemption from disclosure in the Public Records Act for law enforcement records may not apply as the subdivision pertains to police agency records. The Public Records Act does provide that the names and addresses of persons involved in or witnesses to the incident, and statements of witnesses are disclosable. Therefore, claimants can be expected to argue that names of witnesses and other descriptive information similar to that contained in accident reports or police re-

275 As used in this section, “determinations” include findings, reports, transcripts, and orders created in administrative proceedings held by the Commissioner.
276 Gov’t Code § 6250 et al.
279 Gov’t Code § 6254, subd. (b). Thus, to the extent the Commissioner may be litigating an unfair claims handling determination in the courts, disclosure would not be permitted. However, the exemption from disclosure would only last through the settlement or finality of the litigation. Id.
281 Gov’t Code § 6254, subd. (f). (f).
282 Gov’t Code § 6253.
283 Gov’t Code § 6254, subd. (f).
284 Gov’t Code § 6254, subd. (f).
ports that may be contained in the Commissioner’s determinations, including the transcripts of hearings, are discoverable as well.

2. Discovery Requests for Commissioner’s Determinations in Subsequent Litigation

Litigants may obtain discovery via interrogatories, document production demands, or depositions of claims handling personnel. Regardless of the discovery mechanism, the standards for determining whether discovery can be obtained will be the same. Generally, discovery may be obtained of any non-privileged matter that is relevant to the issues being litigated or appears reasonably calculated to lead to the discovery of admissible evidence. Because the Commissioner’s determinations necessarily address issues that pertain to claims handling, courts are likely to refer to precedent involving the discovery of claims information in general to decide whether the determination is discoverable in a given case.

The principal requirement for discovery of claims handling information is a demonstration that the requested discovery is not privileged and that it is relevant to the issue being litigated. Information in claims files may constitute evidence as to whether the licensee and/or insurer properly investigated the claim, acted in good faith to determine whether the claim was covered, or attempted in good faith to settle the claim consistent with an analysis of liability. Where an insurer disputes coverage, policyholders have claimed that, if claims files contain evidence of settlement payments to similarly situated policy holders, this is evidence demonstrating the insurer believed coverage existed under the policy. In view of these arguments, courts have held claims handling information discoverable in bad faith actions only if the requested information is sufficiently similar to the issues being litigated.

In Moradi-Shalal v. Fireman’s Fund Ins. Cos., 46 Cal.3d 287, 250 Cal.Rptr. 116 (1988), the California Supreme Court held that a private party does not have a cause of action under Insurance Code section 790.03, subdivision (h), for unfair claims handling practices. It is arguable, in light of Moradi-Shalal, that it would be inappropriate to permit discovery by a private litigant of the Commissioner’s determination in litigation against an insurer. However, the issue of discoverability will more likely turn on the relevance of the Commissioner’s dete-

287 Claims files concerning an individual may be privileged under state statute. For example, claims files are within the claimants’ right to privacy under Calif. Ins. Code § 791-791.26 et seq. In addition, claims files may contain privileged communications made in the course of an attorney-client relationship, or documents that are the work-product of either the insured or the insurer. Lastly, claims files may contain confidential proprietary information pertaining to manufacturing processes or trade secrets, particularly in claims involving products liability, toxic torts, or environmental liability.
288 As stated in Moore v. American United Life Ins. Co., 150 Cal.App.3d 610, 197 Cal.Rptr. 878 (1984), “In order to establish a pattern of unfair claims practices, the antecedent practice must be substantially similar.” 150 Cal.App.3d at 625. See also Mead Reinsurance Co. v. Superior Court, 188 Cal.App.3d 313, 232 Cal.Rptr. 752 (1988). Many policyholders have argued that all claims handling information is discoverable on the basis of Colonial Life & Accident Ins. Co. v. Superior Court, 31 Cal.3d 785, 183 Cal.Rptr. 810 (1982), in which the California Supreme Court held that claims handling information was discoverable. However, claimants’ attorneys often ignore the fact that in Colonial Life, only 32 files were at issue, and all files were handled by the same adjuster. See also Samson v. Transamerica Ins. Co., 30 Cal.3d 220, 178 Cal.Rptr. 343 (1981) (evidence of setting reserve).
mination to the case at hand. That inquiry may depend on the similarity in the rights asserted by the private litigant to the issues before the Commissioner.

3. Admissibility in Subsequent Litigation

A further question is whether a determination by the Commissioner may be admissible in subsequent litigation. Obviously, depending on the nature of the determination, both insurers and claimants can be expected to argue that the administrative determination should be admissible.

For example, if a subsequent civil action is brought by a claimant after a licensee is found not to have engaged in unfair claims handling in an administrative hearing, the insurer and/or licensee may argue that the determination is admissible to show that no unfair claims handling practice occurred. Similarly, in the event of a determination that a licensee engaged in unfair claims handling practices, the claimant whose claim was subject to the administrative proceeding may argue that the determination provides evidence of bad faith. Lastly, a claimant may attempt to employ a determination involving another claimant as evidence of an insurer’s bad faith practices.

In actions for bad faith, courts are more likely to hold the determinations made by the Commissioner are admissible if they involve substantially similar circumstances (i.e., the same claimant and claim, similar policies, the same type of claim, and the same claims personnel) as the case at hand. Conversely, a determination by the Commissioner that involves different claimants, policies, types of claims and claims personnel, is less likely to be deemed admissible in subsequent litigation.

4. Res Judicata/Collateral Estoppel

Licensees and claimants alike may also argue that a determination by the Commissioner prevents subsequent litigation of issues involving the same claims handling practices, because those issues have already been decided by the Commissioner. Litigation in subsequent actions may be affected by resolutions reached in prior judicial or quasi-judicial admin-
istructive proceedings (such as determinations in proceedings initiated by the Commissioner), under the doctrines of res judicata and collateral estoppel. The purpose of these doctrines is to discourage repeated litigation of the same issue or action once a party has had a full and fair opportunity to litigate it.

Traditionally, the doctrine of collateral estoppel was held inapplicable unless the subsequent proceeding involved parties identical to a prior proceeding. However, as court congestion and the complexity and cost of proceedings increased, the courts broadened the application of the collateral estoppel and res judicata doctrines to allow persons who were not parties to prior proceedings to assert those determinations in subsequent proceedings. In *Bernhard v. Bank of America Nat. Trust*, the California Supreme Court held that, in a subsequent action, a non-party could assert the resolution of an issue in a prior proceeding if:

- the issue decided in the prior proceeding was identical to the one presented for resolution in the subsequent action;
- the decision in the prior proceeding is a final decision on the merits; and
- the party against whom the prior resolution is asserted was a party to, or in privity with a party to, the prior proceeding.

Thus, as originally envisioned by the Supreme Court, collateral estoppel was to be used defensively, i.e., the defendant in a subsequent action could rely on the resolution of an issue in a prior proceeding as a defense to a claim in a subsequent action as to an issue actually litigated in the prior proceeding. However, questions were then raised as to whether a non-party plaintiff could employ a prior resolution “offensively” to establish an element of a cause of action or issue asserted against the party to the prior proceeding.

Offensive use of a prior resolution has been criticized on many grounds, most commonly that it favors plaintiffs too heavily. The argument against offensive use is that a plaintiff can avoid joining in a prior proceeding to await the outcome, and if the outcome is favorable to the plaintiff’s position, then the plaintiff can assert the prior resolution in a subsequent action. If the decision is unfavorable, the plaintiff is not bound by the prior resolution on the basis there was no relationship between the plaintiff in the subsequent action and the plaintiff in the prior

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291 Meaning that it “settles the rights of the parties and disposes of all issues in controversy…” Black’s Law Dictionary 859 (8th ed. 1999).
292 Meaning that it is “based on the evidence rather than on technical or procedural grounds.” Black’s Law Dictionary 860 (8th ed. 1999).
proceeding. In considering the "fairness" of offensive collateral estoppel, courts have looked to the circumstances of the prior resolution such as the ability of counsel, the amount at issue in the prior resolution in contrast to that involved in the subsequent action, and the length of the prior proceeding.\textsuperscript{296} Some courts have also questioned whether allowance of the use of a single prior adverse determination is unfair if there are numerous other decisions reaching a favorable result. In California, there are conflicting decisions on whether the offensive use of a prior judgment is permissible, but an increasing number of decisions support the modern trend to allow offensive use of a prior resolution.\textsuperscript{297}

Very few court decisions have considered whether a claimant can use an administrative determination offensively in subsequent litigation. In \textit{Imen v. Glassford},\textsuperscript{298} property owners who had sued a real estate broker for fraud sought to rely on the real estate commissioner’s determination revoking the broker’s license because he defrauded the property owners. The property owners moved for summary judgment in the subsequent litigation, citing the prior administrative determination. The court considered whether the factors listed in \textit{Bernhard v. Bank of America} were present, in holding that since the party who was sought to be bound by the prior determination had the incentive to vigorously contest the determination, it was fair to use that determination in a subsequent civil action. The court also noted it was fair to use the prior determination because it would encourage participants in administrative hearings to treat the proceeding seriously.\textsuperscript{299}

Proceedings initiated by the Commissioner will sometimes involve licensees other than insurers, such as insurance agents. In such cases, claimants may attempt to use administrative determinations involving licensees against insurers that may not have been subject to the determination. In determining whether an insurer who was not a party to the administrative proceeding is bound by such determination, the focus of the courts will be on the same elements of privity and fairness applied in all cases of res judicata and collateral estoppel. Where an insurer did not authorize, ratify, or approve the conduct of the licensee, a strong argument can be made that the essential element of privity is lacking, and that the insurer had no opportunity or incentive to appear in the prior administrative proceeding. However, the effect of agency theory on such an argument has not been resolved by the courts.


\textsuperscript{299} 201 Cal.App.3d at 907; see also \textit{People v. Sims}, 32 Cal.3d 468, 186 Cal.Rptr. 77 (1982) (commenting on use of prior administrative determinations in subsequent litigation).
CALIFORNIA INSURANCE CODE
DIVISION 1. General Rules Governing Insurance
PART 2. The Business of Insurance
CHAPTER 1. General Regulations
Article 6.5 Unfair Practices

§ 790.03. Prohibited unfair or deceptive acts or practices

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

(a) Making, issuing, circulating, or causing to be made, issued or circulated, any estimate, illustration, circular or statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon, or making any false or misleading statement as to the dividends or share of surplus previously paid on similar policies, or making any misleading representation or any misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates, or using any name or title of any policy or class of policies misrepresenting the true nature thereof, or making any misrepresentation to any policyholder insured in any company for the purpose of inducing or tending to induce the policyholder to lapse, forfeit, or surrender his or her insurance.

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

(c) Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.

(d) Filing with any supervisory or other public official, or making, publishing, disseminating, circulating, or delivering to any person, or placing before the public, or causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public any false statement of financial condition of an insurer with intent to deceive.

(e) Making any false entry in any book, report, or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to whom the insurer is required by law to report, or who has authority by law to examine into its condition or into any of its affairs, or, with like intent, willfully omitting to make a true entry of any material fact pertaining to the business of the insurer in any book, report, or statement of the insurer.
(f) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of the contract.

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

However, for any contract of ordinary life insurance or individual life annuity applied for and issued on or after January 1, 1981, but before the compliance date, in lieu of those differentials based on data segregated by sex, rates, or dividends or benefits, or any combination thereof, for ordinary life insurance or individual life annuity on a female life may be calculated as follows: (a) according to an age not less than three years nor more than six years younger than the actual age of the female insured or female annuitant, in the case of a contract of ordinary life insurance with a face value greater than five thousand dollars ($5,000) or a contract of individual life annuity; and (b) according to an age not more than six years younger than the actual age of the female insured, in the case of a contract of ordinary life insurance with a face value of five thousand dollars ($5,000) or less. “Compliance date” as used in this paragraph shall mean the date or dates established as the operative date or dates by future amendments to this code directing and authorizing life insurers to use a mortality table containing mortality data segregated by sex for the calculation of adjusted premiums and present values for nonforfeiture benefits and valuation reserves as specified in Sections 10163.5 and 10489.2 or successor sections.

Notwithstanding the provisions of this subdivision, sex-based differentials in rates or dividends or benefits, or any combination thereof, shall not be required for (1) any contract of life insurance or life annuity issued pursuant to arrangements which may be considered terms, conditions, or privileges of employment as these terms are used in Title VII of the Civil Rights Act of 1964 (Public Law 88-352), as amended, and (2) tax sheltered annuities for employees of public schools or of tax exempt organizations described in Section 501(c)(3) of the Internal Revenue Code.

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

h) Knowingly committing or performing with such frequency as to indicate a general business practice any of the following unfair claims settlement practices:
(1) Misrepresenting to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.

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

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

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

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

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

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

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

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

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

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

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

(13) Failing to provide promptly a reasonable explanation of the basis relied on in the insurance policy, in relation to the facts or applicable law, for the denial of a claim or for the offer of a compromise settlement.
(14) Directly advising a claimant not to obtain the services of an attorney.

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

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

(i) Canceling or refusing to renew a policy in violation of Section 676.10.
FAIR CLAIMS SETTLEMENT PRACTICES REGULATIONS

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§ 2695.1. Preamble.

(a) Section 790.03(h) of the California Insurance Code enumerates sixteen claims settlement practices that, when either knowingly committed on a single occasion, or performed with such frequency as to indicate a general business practice, are considered to be unfair claims settlement practices and are, thus, prohibited by this section of the California Insurance Code. The Insurance Commissioner has promulgated these regulations in order to accomplish the following objectives:

1. To delineate certain minimum standards for the settlement of claims which, when violated knowingly on a single occasion or performed with such frequency as to indicate a general business practice shall constitute an unfair claims settlement practice within the meaning of Insurance Code Section 790.03(h);

2. To promote the good faith, prompt, efficient and equitable settlement of claims on a cost effective basis;

3. To discourage and monitor the presentation to insurers of false or fraudulent claims; and,

4. To encourage the prompt and thorough investigation of suspected fraudulent claims and ensure the prompt and comprehensive reporting of suspected fraudulent claims as required by Insurance Code Section 1872.4.

(b) These regulations are not meant to provide the exclusive definition of all unfair claims settlement practices. Other methods, act(s), or practices not specifically delineated in this set of regulations may also be unfair claims settlement practices and subject to California Insurance Code Section 790.03(h) and/or California Insurance Code Section 790.06. These regulations are applicable to the handling or settlement of all claims subject to Article 6.5 of Division 1, Part 2, Chapter 1 of the California Insurance Code, commencing with Section 790, except as specifically provided below:

1. Workers’ compensation insurance;

2. Liability insurance for the professional malpractice of health care providers as defined in California Code of Civil Procedure Section 364(f)(1);

3. Self insured or self funded plans which are bona fide Employee Retirement Income Security Act (“ERISA”) plans which are not also multiple employer welfare arrangements, to the extent that these ERISA plans are not covered by insurance;

4. Any other self funded or self insured plan, to the extent it is not covered by insurance, which is lawfully conducting business in this state.

(c) In recognition of both the unique relationship which exists under a surety bond between the surety, the obligee or beneficiary, and the principal, and the fact that the processing of
surety claims is subject to the Unfair Practices Act, beginning with California Insurance Code Section 790, only sections 2695.1 through 2695.6, inclusive, section 2695.10, and sections 2695.12, 2695.13 and 2695.14, inclusive, shall apply to the handling or settlement of claims brought under surety bonds.

(d) These regulations apply to home protection contracts and home protection companies defined in California Insurance Code Section 12740.

(e) All licensees, as defined in these regulations, shall have thorough knowledge of the regulations contained in this subchapter.

(f) Policy provisions relating to the investigation, processing and settlement of claims shall be consistent with or more favorable to the insured than the provisions of these regulations.

(g) The California Insurance Code provides the commissioner with access to all records of an insurer and the power to examine the affairs of every person engaged in the business of insurance to determine if such person is engaged in any unfair or deceptive act or practice. California Insurance Code Section 790.03(h) requires all persons engaged in the business of insurance to effectuate prompt, fair and equitable settlements of claims and to otherwise process claims in a fair and reasonable manner. The Department considers the use of reliable information to be an essential element of the fair and equitable settlement of claims. The fact that information, data or statistical methods used or relied upon by a licensee to process or establish the value of insurance claims is obtained through a third party source shall not absolve the licensee of its legal responsibility to comply with these regulations or to effectuate prompt, fair and equitable settlements of claims. Failure of a licensee to provide the commissioner with requested information sufficient to examine the licensee’s claims handling practices may justify a finding that the licensee was in non-compliance with these regulations or other applicable insurance code provisions. Any and all information received pursuant to the Department’s request shall be given confidential treatment, as provided in California Insurance Code section 735.5 and California Government Code Section 11180 et seq. When processing or establishing the value of a claim, a licensee shall not be responsible for the accuracy of information provided by a governmental entity, unless the licensee has discovered or been notified of the inaccuracy and has continued to use the information.

Note: Authority cited: Sections 790.034, 790.10, 1871.1, 12340-12417, inclusive, 12921 and 12926, Insurance Code; and Sections 11152 and 11342.2, Government Code. Reference: Sections 735.5, 790.03(h) and 12740, Insurance Code; and Section 11180, Government Code.

§ 2695.2. Definitions.

As used in these regulations:

a) “Beneficiary” means:

(1) for the purpose of life and disability claims, the party or parties entitled to receive the proceeds or benefits occurring under the policy in lieu of the insured; or,
(2) for the purpose of surety claims, a person who is within the class of persons intended to benefit from the bond;

(b) "Calendar days" means each and every day including Saturdays, Sundays, Federal and California State Holidays, but if the last day for performance of any act required by these regulations falls on a Saturday, Sunday, Federal or State Holiday, then the period of time to perform the act is extended to and including the next calendar day which is not a Saturday, Sunday, or Federal or State holiday;

(c) "Claimant" means a first or third party claimant as defined in these regulations, any person who asserts a right of recovery under a surety bond, an attorney, any person authorized by operation of law to represent the claimant, or any of the following persons properly designated by the claimant in the manner specified in subsection 2695.5(c): an insurance adjuster, a public adjuster, or any member of the claimant's family.

(d) "Claims agent" means any person employed or authorized by an insurer, to conduct an investigation of a claim on behalf of an insurer or a person who is licensed by the Commissioner to conduct investigations of claims on behalf of an insurer. The term "claims agent", however, shall not include the following:

(1) an attorney retained by an insurer to defend a claim brought against an insured; or,

(2) persons hired by an insurer solely to provide valuation as to the subject matter of a claim.

(e) "Extraordinary circumstances" means circumstances outside of the control of the licensee which severely and materially affect the licensee's ability to conduct normal business operations;

(f) "First party claimant" means any person asserting a right under an insurance policy as a named insured, other insured or beneficiary under the terms of that insurance policy, and including any person seeking recovery of uninsured motorist benefits;

(g) "Gross settlement amount" means the amount tendered plus the amount deducted as provided in the policy in the settlement of an automobile total loss claim;

(h) "Insurance agent" means:

(1) the term "insurance agent" as used in section 31 of the California Insurance Code; or,

(2) the term "life agent" as used in section 32 of the California Insurance Code; or,

(3) any person who has authority or responsibility to notify an insurer of a claim upon receipt of a notice of claim by a claimant; or,

(4) an underwritten title company.
(i) “Insurer” means a person licensed to issue or that issues an insurance policy or surety bond in this state, or that otherwise transacts the business of insurance in the state, including reciprocal and interinsurance exchanges, fraternal benefit societies, stock and mutual insurance companies, risk retention groups, California county mutual fire insurance companies, grants and annuities societies, entities holding certificates of exemption, non-profit hospital service plans, multiple employer welfare arrangements holding certificates of compliance pursuant to Article 4.7 of the California Insurance Code, and motor clubs, to the extent that they transact the business of insurance in the State. The term “insurer” for purposes of these regulations includes non-admitted insurers, the California FAIR Plan, the California Earthquake Authority, those persons licensed to issue or that issue an insurance policy pursuant to an assignment by the California Automobile Assigned Risk Plan, home protection companies as defined under California Insurance Code Section 12740, and any other entity subject to California Insurance Code Section 790.03(h). The term “insurer” shall not include insurance agents and brokers, surplus line brokers and special lines surplus line brokers.

(j) “Insurance policy” or “policy” means the written instrument in which any certificate of group insurance, contract of insurance, or non-profit hospital service plan is set forth. For the purposes of these regulations the terms insurance policy or policy do not include “surety bond” or “bond”. For the purposes of these regulations the term insurance policy or policy includes a home protection contract or any written instrument in which any certificate of insurance or contract of insurance is set forth that is issued pursuant to the California Automobile Assigned Risk Plan, the California Earthquake Authority, or the California FAIR Plan;

k) “Investigation” means all activities of an insurer or its claims agent related to the determination of coverage, liabilities, or nature and extent of loss or damage for which benefits are afforded by an insurance policy, obligations or duties under a bond, and other obligations or duties arising from an insurance policy or bond.

(l) “Knowingly committed” means performed with actual, implied or constructive knowledge, including, but not limited to, that which is implied by operation of law.

(m) “Licensee” means any person that holds a license or Certificate of Authority from the Insurance Commissioner, or any other entity for whom the Insurance Commissioner’s consent is required before transacting business in the State of California or with California residents. The term “licensee” for purpose of these regulations does not include an underwritten title company if the underwriting agreement between the underwritten title company and the title insurer affirmatively states that the underwritten title company is not authorized to handle policy claims on behalf of the title insurer.

(n) “Notice of claim” means any written or oral notification to an insurer or its agent that reasonably apprises the insurer that the claimant wishes to make a claim against a policy or bond issued by the insurer and that a condition giving rise to the insurer’s obligations under that policy or bond may have arisen. For purposes of these regulations the term “notice of claim” shall not include any written or oral communication provided by an insured or principal solely for informational or incident reporting purposes.
(o) "Notice of legal action" means notice of an action commenced against the insurer with respect to a claim, or notice of action against the insured received by the insurer, or notice of action against the principal under a bond, and includes any arbitration proceeding;

(p) "Obligee" means the person named as obligee in a bond;

(q) "Person" means any individual, association, organization, partnership, business, trust, corporation or other entity;

(r) "Principal" means the person whose debt or other obligation is secured or guaranteed by a bond and who has the primary duty to pay the debt or discharge the obligation;

(s) "Proof of claim" means any evidence or documentation in the possession of the insurer, whether as a result of its having been submitted by the claimant or obtained by the insurer in the course of its investigation, that provides any evidence of the claim and that reasonably supports the magnitude or the amount of the claimed loss.

(t) "Remedial measures" means those actions taken by an insurer to correct or cure any error or omission in the handling of claims on the part of its insurance agent as defined in subsection 2695.2(h), including, but not limited to:

(1) written notice to the insurance agent that he/she is in violation of the regulations contained in this subchapter;

(2) transmission of a copy of the regulations contained in this subchapter and instructions for their implementation;

(3) reporting the error or omission in the handling of claims by the insurance agent to the Department of Insurance;

(u) "Replacement crash part" means a replacement for any of the nonmechanical sheet metal or plastic parts which generally constitute the exterior of a motor vehicle, including inner and outer panels;

(v) "Single act" for the purpose of determining any penalty pursuant to California Insurance Code Section 790.035 is any commission or omission which in and of itself constitutes a violation of California Insurance Code Section 790.03 or this subchapter;

(w) "Surety bond" or "bond" means the written instrument in which a contract of surety insurance, as defined in California Insurance Code Section 105, is set forth;

(x) "Third party claimant" means any person asserting a claim against any person or the interests insured under an insurance policy;

(y) "Willful" or "Willfully" when applied to the intent with which an act is done or omitted means simply a purpose or willingness to commit the act, or make the omission referred to in the
California Insurance Code or this subchapter. It does not require any intent to violate law, or to injure another, or to acquire any advantage;

Note: Authority cited: Sections 132(d), 790.10, 12340-12417, inclusive, 12921 and 12926, Insurance Code; Section 995.130, Code of Civil Procedure; and Sections 11152 and 11342.2, Government Code. Reference: Sections 31, 32, 101, 106, 675.5(b), (c) and (d), 676.6, 790.03(h) and 10082, Insurance Code.

§ 2695.3. File and Record Documentation.

(a) Every licensee’s claim files shall be subject to examination by the Commissioner or by his or her duly appointed designees. These files shall contain all documents, notes and work papers (including copies of all correspondence) which reasonably pertain to each claim in such detail that pertinent events and the dates of the events can be reconstructed and the licensee’s actions pertaining to the claim can be determined;

(b) To assist in such examination all insurers shall:

(1) maintain claim data that are accessible, legible and retrievable for examination so that an insurer shall be able to provide the claim number, line of coverage, date of loss and date of payment of the claim, date of acceptance, denial or date closed without payment. This data must be available for all open and closed files for the current year and the four preceding years;

(2) record in the file the date the licensee received, date(s) the licensee processed and date the licensee transmitted or mailed every material and relevant document in the file; and

(3) maintain hard copy files or maintain claim files that are accessible, legible and capable of duplication to hard copy; files shall be maintained for the current year and the preceding four years.

(c) The requirements of this section shall be satisfied where the licensee provides documentation evidencing inability to obtain data, nonexistence of data, or difficulty in obtaining clear documentary support for actions due to catastrophic losses, or other unusual circumstances providing the licensee establishes to the satisfaction of the Commissioner that the circumstances alleged by the licensee do exist and have materially affected the licensee’s ability to comply with this regulation. Any licensee that alleges an inability to comply with this section shall establish and submit to the Commissioner a plan for file and record documentation to be used by such licensee while the circumstances alleged to preclude compliance with this subsection continue to exist.

Note: Authority cited: Sections 790.04, 790.10, 12340-12417, inclusive, 12921 and 12926, Insurance Code; and Sections 11342.2 and 11152, Government Code. Reference: Section 790.03(h), Insurance Code.
§ 2695.4. Representation of Policy Provisions and Benefits.

(a) Every insurer shall disclose to a first party claimant or beneficiary, all benefits, coverage, time limits or other provisions of any insurance policy issued by that insurer that may apply to the claim presented by the claimant. When additional benefits might reasonably be payable under an insured’s policy upon receipt of additional proofs of claim, the insurer shall immediately communicate this fact to the insured and cooperate with and assist the insured in determining the extent of the insurer’s additional liability.

(b) No insurer shall misrepresent or conceal benefits, coverages, time limits or other provisions of the bond which may apply to the claim presented under a surety bond.

(c) No insurer shall deny a claim on the basis of the claimant’s failure to exhibit property, unless there is documentation in the file (1) of reasonable demand by the insurer, and unfounded refusal by the claimant, to exhibit property, or (2) of the breach of any policy provision providing for the exhibition of property.

(d) Except where a time limit is specified in the policy, no insurer shall require a first party claimant under a policy to give notification of a claim or proof of claim within a specified time.

(e) No insurer shall:

(1) request that a claimant sign a release that extends beyond the subject matter which gave rise to the claim payment unless, prior to execution of the release, the legal effect of the release is disclosed and fully explained by the insurer to the claimant in writing. For purposes of this subsection, an insurer shall not be required to provide the above explanation or disclosure to a claimant who is represented by an attorney at the time the release is presented for signature;

(2) be precluded from including in any release a provision requiring the claimant to waive the provisions of California Civil Code Section 1542 provided that, prior to execution of the release, the legal effect of the release is disclosed and fully explained by the insurer to the claimant in writing. For purposes of this subsection, an insurer shall not be required to provide the above explanation or disclosure to a claimant who is represented by an attorney at the time the release is presented for signature.

(f) No insurer shall issue checks or drafts in partial settlement of a loss or claim that contain or are accompanied by language releasing the insurer, the insured, or the principal on a surety bond from total liability unless the policy or bond limit has been paid, or there has been a compromise settlement agreed to by the claimant and the insurer as to coverage and amount payable under the insurance policy or bond.

(g) No insurer shall require a first party claimant or beneficiary to submit duplicative proofs of claim where coverage may exist under more than one policy issued by that insurer.

Note: Authority cited: Sections 790.10, 12340-12417, inclusive, 12921 and 12926, Insurance
Code; and Sections 11152 and 11342.2, Government Code. Reference: Sections 790.03(h) (1), (3) and (4), Insurance Code.

§ 2695.5. Duties Upon Receipt of Communications.

(a) Upon receiving any written or oral inquiry from the Department of Insurance concerning a claim, every licensee shall immediately, but in no event more than twenty-one (21) calendar days of receipt of that inquiry, furnish the Department of Insurance with a complete written response based on the facts as then known by the licensee. A complete written response addresses all issues raised by the Department of Insurance in its inquiry and includes copies of any documentation and claim files requested. This section is not intended to permit delay in responding to inquiries by Department personnel conducting a scheduled examination on the insurer’s premises.

(b) Upon receiving any communication from a claimant, regarding a claim, that reasonably suggests that a response is expected, every licensee shall immediately, but in no event more than fifteen (15) calendar days after receipt of that communication, furnish the claimant with a complete response based on the facts as then known by the licensee. This subsection shall not apply to require communication with a claimant subsequent to receipt by the licensee of a notice of legal action by that claimant.

(c) The designation specified in subsection 2695.2(c) shall be in writing, signed and dated by the claimant, and shall indicate that the designated person is authorized to handle the claim. All designations shall be transmitted to the insurer and shall be valid from the date of execution until the claim is settled or the designation is revoked. A designation may be revoked by a writing transmitted to the insurer, signed and dated by the claimant, indicating that the designation is to be revoked and the effective date of the revocation.

(d) Upon receiving notice of claim, every licensee or claims agent shall immediately transmit notice of claim to the insurer.

(e) Upon receiving notice of claim, every insurer shall immediately, but in no event more than fifteen (15) calendar days later, do the following unless the notice of claim received is a notice of legal action:

(1) acknowledge receipt of such notice to the claimant unless payment is made within that period of time. If the acknowledgement is not in writing, a notation of acknowledgement shall be made in the insurer’s claim file and dated. Failure of an insurance agent or claims agent to promptly transmit notice of claim to the insurer shall be imputed to the insurer except where the subject policy was issued pursuant to the California Automobile Assigned Risk Program.

(2) provide to the claimant necessary forms, instructions, and reasonable assistance, including but not limited to, specifying the information the claimant must provide for proof of claim;

(3) begin any necessary investigation of the claim.
(f) An insurer may not require that the notice of claim under a policy be provided in writing unless such requirement is specified in the insurance policy or an endorsement thereto.

Note: Authority cited: Sections 790.04, 790.10, 12340-12417, inclusive, 12921, 12926, Insurance Code; and Sections 11342.2 and 11152, Government Code. Reference: Sections 790.03(h)(2) and (3), Insurance Code.

§ 2695.6. Training and Certification.

(a) Every insurer shall adopt and communicate to all its claims agents written standards for the prompt investigation and processing of claims, and shall do so within ninety (90) days after the effective date of these regulations or any revisions thereto.

(b) All licensees shall provide thorough and adequate training regarding the regulations to all their claims agents. Licensees shall certify that their claims agents have been trained regarding these regulations and any revisions thereto. However, licensees need not provide such training or certification to duly licensed attorneys.

A licensee shall demonstrate compliance with this subsection by the following methods:

(1) where the licensee is an individual, the licensee shall annually certify in writing under penalty of perjury that he or she has read and understands the regulations and any and all amendments thereto;

(2) where the licensee is an entity, the annual written certification shall be executed, under penalty of perjury, by a principal of the entity as follows:

(A) that the licensee’s claims adjusting manual contains a copy of these regulations and all amendments thereto; and, 

(B) that clear written instructions regarding the procedures to be followed to effect proper compliance with this subchapter were provided to all its claims agents;

(3) where the licensee retains insurance adjusters as defined in California Insurance Code Section 14021, the licensee must provide training to the insurance adjusters regarding these regulations and annually certify, in a declaration executed under penalty of perjury, that such training is provided. Alternately, the insurance adjuster may annually certify in writing, under penalty of perjury, that he or she has read and understands these regulations and all amendments thereto or has successfully completed a training seminar which explains these regulations;

(4) a copy of the certification required by subsections 2695.6(b)(1), (2) or (3) shall be maintained at all times at the principal place of business of the licensee, to be provided to the Commissioner only upon request.

(5) the annual certification required by this subsection shall be completed on or before September 1 of each calendar year.
§ 2695.7. Standards for Prompt, Fair and Equitable Settlements.

(a) No insurer shall discriminate in its claims settlement practices based upon the claimant’s age, race, gender, income, religion, language, sexual orientation, ancestry, national origin, or physical disability, or upon the territory of the property or person insured.

(b) Upon receiving proof of claim, every insurer, except as specified in subsection 2695.7(b)(4) below, shall immediately, but in no event more than forty (40) calendar days later, accept or deny the claim, in whole or in part. The amounts accepted or denied shall be clearly documented in the claim file unless the claim has been denied in its entirety.

(1) Where an insurer denies or rejects a first party claim, in whole or in part, it shall do so in writing and shall provide to the claimant a statement listing all bases for such rejection or denial and the factual and legal bases for each reason given for such rejection or denial which is then within the insurer’s knowledge. Where an insurer’s denial of a first party claim, in whole or in part, is based on a specific statute, applicable law or policy provision, condition or exclusion, the written denial shall include reference thereto and provide an explanation of the application of the statute, applicable law or provision, condition or exclusion to the claim. Every insurer that denies or rejects a third party claim, in whole or in part, or disputes liability or damages shall do so in writing.

(2) Subject to the provisions of subsection 2695.7(k), nothing contained in subsection 2695.7(b)(1) shall require 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.

(3) Written notification pursuant to this subsection shall include a statement that, if the claimant believes all or part of the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance, and shall include the address and telephone number of the unit of the Department which reviews claims practices.

(4) The time frame in subsection 2695.7(b) shall not apply to claims arising from policies of disability insurance subject to Section 10123.13 of the California Insurance Code, disability income insurance subject to Section 10111.2 of the California Insurance Code or mortgage guaranty insurance subject to Section 12640.09(a) of the California Insurance Code, and shall not apply to automobile repair bills arising from policies of automobile collision and comprehensive insurance subject to Section 560 of the California Insurance Code. All other provisions of subsections 2695.7(b)(1), (2), and (3) are applicable.

(c)(1) If more time is required than is allotted in subsection 2695.7(b) to determine whether a claim should be accepted and/or denied in whole or in part, every insurer shall provide
the claimant, within the time frame specified in subsection 2695.7(b), with written notice of the need for additional time. This written notice shall specify any additional information the insurer requires in order to make a determination and state any continuing reasons for the insurer’s inability to make a determination. Thereafter, the written notice shall be provided every thirty (30) calendar days until a determination is made or notice of legal action is served. If the determination cannot be made until some future event occurs, then the insurer shall comply with this continuing notice requirement by advising the claimant of the situation and providing an estimate as to when the determination can be made.

(2) Subject to the provisions of subsection 2695.7(k), nothing contained in subsection 2695.7(c)(1) shall require an insurer to disclose any information that could reasonably be expected to alert a claimant to the fact that the claim is being investigated as a possible suspected fraudulent claim.

(d) Every insurer shall conduct and diligently pursue a thorough, fair and objective investigation and shall not persist in seeking information not reasonably required for or material to the resolution of a claim dispute.

(e) No insurer shall delay or deny settlement of 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, statutes or regulations, including those pertaining to coordination of benefits.

(f) Except where a claim has been settled by payment, every insurer shall provide written notice of any statute of limitation or other time period requirement upon which the insurer may rely to deny a claim. Such notice shall be given to the claimant not less than sixty (60) days prior to the expiration date; except, if notice of claim is first received by the insurer within that sixty days, then notice of the expiration date must be given to the claimant immediately. With respect to a first party claimant in a matter involving an uninsured motorist, this notice shall be given at least thirty (30) days prior to the expiration date; except, if notice of claim is first received by the insurer within that thirty days, then notice of the expiration date must be given to the claimant immediately. This subsection shall not apply to a claimant represented by counsel on the claim matter.

(g) No insurer shall attempt to settle a claim by making a settlement offer that is unreasonably low. The Commissioner shall consider any admissible evidence offered regarding the following factors in determining whether or not a settlement offer is unreasonably low:

(1) the extent to which the insurer considered evidence submitted by the claimant to support the value of the claim;

(2) the extent to which the insurer considered legal authority or evidence made known to it or reasonably available;

(3) the extent to which the insurer considered the advice of its claims adjuster as to the amount of damages;
(4) the extent to which the insurer considered the advice of its counsel that there was a substantial likelihood of recovery in excess of policy limits;

(5) the procedures used by the insurer in determining the dollar amount of property damage;

(6) 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;

(7) any other credible evidence presented to the Commissioner that demonstrates that (i) any amount offered by the insurer in settlement of a first-party claim to an insured not represented by counsel, or (ii) the final amount offered in settlement of a first-party claim to an insured who is represented by counsel or (iii) the final amount offered in settlement of a third party claim by the insurer is below the amount that a reasonable person with knowledge of the facts and circumstances would have offered in settlement of the claim.

(h) Upon acceptance of the claim in whole or in part and, when necessary, upon receipt of a properly executed release, every insurer, except as specified in subsection 2695.7(h)(1) and (2) below, shall immediately, but in no event more than thirty (30) calendar days later, tender payment or otherwise take action to perform its claim obligation. The amount of the claim to be tendered is the amount that has been accepted by the insurer as specified in subsection 2695.7(b). In claims where multiple coverage is involved, and where the payee is known, amounts that have been accepted by the insurer shall be paid immediately, but in no event more than thirty (30) calendar days, if payment would terminate the insurer’s known liability under that individual coverage, unless impairment of the insured’s interests would result. The time frames specified in this subsection shall not apply where the policy provides for a waiting period after acceptance of claim and before payment of benefits.

(1) The time frame specified in subsection 2695.7(h) shall not apply to claims arising from policies of disability insurance subject to Section 10123.13 of the California Insurance Code, disability income insurance subject to Section 10111.2 of the California Insurance Code, or of mortgage guaranty insurance subject to Section 12640.09(a) of the California Insurance Code, and shall not apply to automobile repair bills subject to Section 560 of the California Insurance Code. All other provisions of Section 2695.7(h) are applicable.

(2) Any insurer issuing a title insurance policy shall either tender payment pursuant to subsection 2695.7(h) or take action to resolve the problem which gave rise to the claim immediately upon, but in no event more than thirty (30) calendar days after, acceptance of the claim.

(i) No insurer shall inform a claimant that his or her rights may be impaired if a form or release is not completed within a specified time period unless the information is given for the purpose of notifying the claimant of any applicable statute of limitations or policy provision or the time limitation within which claims are required to be brought against state or local entities.

(j) No insurer shall request or require an insured to submit to a polygraph examination unless authorized under the applicable insurance contract and state law.
(k) Subject to the provisions of subsection 2695.7(c), where there is a reasonable basis, supported by specific information available for review by the California Department of Insurance, for the belief that the claimant has submitted or caused to be submitted to an insurer a suspected false or fraudulent claim as specified in California Penal Code Section 550 or California Insurance Code Section 1871.4(a), the number of calendar days specified in subsection 2695.7(b) shall be:

(1) increased to eighty (80) calendar days; or,

(2) suspended until otherwise ordered by the Commissioner, provided the insurer has complied with California Insurance Code Section 1872.4 and the insurer can demonstrate to the Commissioner that it has made a diligent attempt to determine whether the subject claim is false or fraudulent within the eighty day period specified by subsection 2695.7(k)(1).

(l) No insurer shall deny a claim based upon information obtained in a telephone conversation or personal interview with any source unless the telephone conversation or personal interview is documented in the claim file pursuant to the provisions of Section 2695.3.

(m) No insurer shall make a payment to a provider, pursuant to a policy provision to pay medical benefits, and thereafter seek recovery or set-off from the insured on the basis that the amount was excessive and/or the services were unnecessary, except in the event of a proven false or fraudulent claim, subject to the provisions of Section 10123.145 of the California Insurance Code.

(n) Every insurer requesting a medical examination for the purpose of determining liability under a policy provision shall do so only when the insurer has a good faith belief that such an examination is reasonably necessary.

(o) No insurer shall require that a claimant withdraw, rescind or refrain from submitting any complaint to the California Department of Insurance regarding the handling of a claim or any other matter complained of as a condition precedent to the settlement of any claim.

(p) Every insurer shall provide written notification to a first party claimant as to whether the insurer intends to pursue subrogation of the claim. Where an insurer elects not to pursue subrogation, or discontinues pursuit of subrogation, it shall include in its notification a statement that any recovery to be pursued is the responsibility of the first party claimant. This subsection does not require notification if the deductible is waived, the coverage under which the claim is paid requires no deductible to be paid, the loss sustained does not exceed the applicable deductible, or there is no legal basis for subrogation.

(q) Every insurer that makes a subrogation demand shall include in every demand the first party claimant’s deductible. Every insurer shall share subrogation recoveries on a proportionate basis with the first party claimant, unless the first party claimant has otherwise recovered the whole deductible amount. No insurer shall deduct legal or other expenses from the recovery of the deductible unless the insurer has retained an outside attorney or collection agency to collect that recovery. The deduction may only be for a pro rata share of the allocated loss.
adjustment expense. This subsection shall not apply when multiple policies have been issued to the insured(s) covering the same loss and the language of these contracts prescribe alternative subrogation rights. Further, this subsection shall not apply to disability and health insurance as defined in California Insurance Code Section 106.


§ 2695.8. Additional Standards Applicable to Automobile Insurance.

(a) This section enumerates standards which apply to adjustment and settlement of automobile insurance claims.

(1) the words “automobile” and “vehicle” are used synonymously.

(b) In evaluating automobile total loss claims the following standards shall apply:

(1) The insurer may elect a cash settlement that shall be based upon the actual cost of a “comparable automobile” less any deductible provided in the policy. This cash settlement amount shall include all applicable taxes and one-time fees incident to transfer of evidence of ownership of a comparable automobile. This amount shall also include the license fee and other annual fees to be computed based upon the remaining term of the loss vehicle’s current registration. This procedure shall apply whether or not a replacement automobile is purchased.

(A) If the insured chooses to retain the loss vehicle or if the third party claimant retains the loss vehicle, the cash settlement amount shall include the sales tax associated with the cost of a comparable automobile, discounted by the amount of sales tax attributed to the salvage value of the loss vehicle. The cash settlement amount shall also include all fees incident to transfer of the claimant’s vehicle to salvage status. The salvage value may be deducted from the settlement amount and shall be determined by the amount for which a salvage pool or a licensed salvage dealer, wholesale motor vehicle auction or dismantler will purchase the salvage. If requested by the claimant, the insurer shall provide the name, address and telephone number of the salvage dealer, salvage pool, motor vehicle auction or dismantler who will purchase the salvage. The insurer shall disclose in writing to the claimant that notice of the salvage retention by the claimant must be provided to the Department of Motor Vehicles and that this notice may affect the loss vehicle’s future resale and/or insured value. The disclosure must also inform the claimant of his or her right to seek a refund of the unused license fees from the Department of Motor Vehicles.

(2) A “comparable automobile” is one of like kind and quality, made by the same manufacturer, of the same or newer model year, of the same model type, of a similar body type, with
options and mileage similar to the insured vehicle. Newer model year automobiles may not be used as comparable automobiles unless there are not sufficient comparable automobiles of the same model year to make a determination as set forth in Section 2695.8(b)(3), below. In determining the cost of a comparable automobile, the insurer may use either the asking price or actual sale price of that automobile. Any differences between the comparable automobile and the insured vehicle shall be permitted only if the insurer fairly adjusts for such differences. Any adjustments from the cost of a comparable automobile must be discernible, measurable, itemized, and specified as well as appropriate in dollar amount and so documented in the claim file. Deductions taken from the cost of a comparable automobile that cannot be supported shall not be used. The actual cost of a comparable automobile shall not include any deduction for the condition of a loss vehicle unless the documented condition of the loss vehicle is below average for that particular year, make and model of vehicle. This subsection shall not preclude deduction for prior and/or unrelated damage to the loss vehicle. A comparable automobile must have been available for retail purchase by the general public in the local market area within ninety (90) calendar days of the final settlement offer. The comparable automobiles used to calculate the cost shall be identified by the vehicle identification number (VIN), the stock or order number of the vehicle from a licensed dealer, or the license plate number of that comparable vehicle if this information is available. The identification shall also include the telephone number (including area code) or street address of the seller of the comparable automobile.

(3) Notwithstanding subsection (2), above, upon approval by the Department of Insurance, an insurer may use private sales data from the Department of Motor Vehicles, or other approved sources, which does not contain the seller’s telephone number or street address. Approval by the Department of Insurance shall be contingent on the Department’s determination that reasonable steps have been taken to limit the use of private sales data that may be inaccurately reported to the Department of Motor Vehicles, or other approved sources.

(4) The insurer shall take reasonable steps to verify that the determination of the cost of a comparable vehicle is accurate and representative of the market value of a comparable automobile in the local market area. Upon its request, the department shall have access to all records, data, computer programs, or any other information used by the insurer or any other source to determine market value. The cost of a comparable automobile shall be determined as follows and, once determined, shall be fully itemized and explained in writing for the claimant at the time the settlement offer is made:

(A) when comparable automobiles are available or were available in the local market area in the last 90 days, the average cost of two or more such comparable automobiles; or,

(B) when comparable automobiles are not available or were not available in the local market area in the last 90 days, the average of two or more quotations from two or more licensed dealers in the local market area; or,

(C) the cost of a comparable automobile as determined by a computerized automobile valuation service that produces statistically valid fair market values within the local market area; or

(D) if it is not possible to determine the cost of a comparable automobile by using one of the methods described in subsections (b)(3)(A), (b)(3)(B) and (b)(3)(C) of this section, the
cost of a comparable automobile shall otherwise be supported by documentation and fully explained to the claimant. Any adjustments to the cost of a comparable automobile shall be discernible, measurable, itemized, and specified as well as appropriate in dollar amount and so documented in the claims file. Deductions taken from the cost of a comparable automobile that cannot be supported shall not be used.

(5) In first party automobile total loss claims, the insurer may elect to offer a replacement automobile which is a specified comparable automobile available to the insured with all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of the automobile paid by the insurer at no cost other than any deductible provided in the policy. The offer and any rejection thereof must be documented in the insurer’s claim file. A replacement automobile must be in as good or better overall condition than the insured vehicle and available for inspection within a reasonable distance of the insured’s residence.

(6) Subsection 2695.8(b) applies to the evaluation of third party automobile total loss claims, but does not change existing law with respect to the obligations of an insurer in settling such claims with a third party.

(c) In first party automobile total loss claims, every insurer shall provide notice to the insured at the time the settlement payment is sent or final settlement offer is made that if notified by the insured within thirty-five (35) calendar days after the insured receives the claim payment or final settlement offer that he or she cannot purchase a comparable automobile for the gross settlement amount, the insurer will reopen its claim file. If subsequently notified by the insured the insurer shall reopen its claim file and utilize the following procedures:

(1) The insurer shall locate a comparable automobile for the gross settlement amount determined by the company at the time of settlement and shall provide the insured with the information required in (c)(4), below, or offer a replacement vehicle in accordance with section 2695.8(b)(4). Any such vehicle must be available in the local market area; or,

(2) The insurer shall either pay the insured the difference between the amount of the gross settlement and the cost of the comparable automobile which the insured has located, or negotiate and purchase this vehicle for the insured; or,

(3) The insurer shall invoke the appraisal provision of the insurance policy.

(4) No insurer is required to take action under this subsection if its documentation to the insured at the time of final settlement offer included written notification of the identity of a specified comparable automobile which was available for purchase at the time of final settlement offer for the gross settlement amount determined by the insurer. The documentation shall include the telephone number (including area code) or street address of the seller of the comparable automobile and:

(A) the vehicle identification number (VIN) or,
(B) the stock or order number of the vehicle from a licensed dealer, or

(C) the license plate number of such comparable vehicle.

(d) No insurer shall, where liability and damages are reasonably clear, recommend that the third party claimant make a claim under his or her own policy to avoid paying the claim under the policy issued by that insurer.

(e) No insurer shall:

(1) require that an automobile be repaired at a specific repair shop; or,

(2) suggest or recommend that an automobile be repaired at a specific repair shop, unless all of the requirements set forth in California Insurance Code Section 758.5 have been met.

(3) require a claimant to travel an unreasonable distance either to inspect a replacement automobile, to conduct an inspection of the vehicle, to obtain a repair estimate or to have the automobile repaired at a specific repair shop.

(f) If partial losses are settled on the basis of a written estimate prepared by or for the insurer, the insurer shall supply the claimant with a copy of the estimate upon which the settlement is based. The estimate prepared by or for the insurer shall be of an amount which will allow for repairs to be made in a workmanlike manner. If the claimant subsequently contends, based upon a written estimate which he or she obtains, that necessary repairs will exceed the written estimate prepared by or for the insurer, the insurer shall:

(1) pay the difference between the written estimate and a higher estimate obtained by the claimant; or,

(2) if requested by the claimant, promptly provide the claimant with the name of at least one repair shop that will make the repairs for the amount of the insurer’s written estimate. The insurer shall cause the damaged vehicle to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy or as otherwise allowed by law. The insurer shall maintain documentation of all such communications; or,

(3) reasonably adjust any written estimates prepared by the repair shop of the claimant’s choice and provide a copy of the adjusted estimate to the claimant.

(g) No insurer shall require the use of non-original equipment manufacture replacement crash parts in the repair of an automobile unless:

(1) the parts are at least equal to the original equipment manufacturer parts in terms of kind, quality, safety, fit, and performance;

(2) insurers specifying the use of non-original equipment manufacturer replacement crash parts shall pay the cost of any modifications to the parts which may become necessary to
effect the repair; and,

(3) insurers specifying the use of non-original equipment manufacture replacement crash parts warrant that such parts are of like kind, quality, safety, fit, and performance as original equipment manufacturer replacement crash parts; and,

(4) all original and non-original manufacture replacement crash parts, manufactured after the effective date of this subchapter, when supplied by repair shops shall carry sufficient permanent, non-removable identification so as to identify the manufacturer. Such identification shall be accessible to the greatest extent possible after installation; and,

(5) the use of non-original equipment manufacturer replacement crash parts is disclosed in accordance with section 9875 of the California Business and Professions Code.

(h) No insurer shall require an insured or claimant to supply parts for replacement.

(i) When the amount claimed is adjusted because of betterment or depreciation, all justification shall be contained in the claim file. Any adjustments shall be discernable, measurable, itemized, and specified as to dollar amount, and shall accurately reflect the value of the betterment or depreciation. This subsection shall not preclude deduction for prior and/or unrelated damage to the loss vehicle. The basis for any adjustment shall be fully explained to the claimant in writing and shall:

(1) reflect a measurable difference in market value attributable to the condition and age of the vehicle, and

(2) apply only to parts normally subject to repair and replacement during the useful life of the vehicle such as, but not limited to, tires, batteries, et cetera.

(j) In a first party partial loss claim, the expense of labor necessary to repair or replace the damage is not subject to depreciation or betterment unless the insurance contract contains a clear and unambiguous provision permitting the depreciation of the expense of labor.

(k) After a covered loss under a policy of automobile collision coverage or automobile physical damage coverage as defined in California Insurance Code Section 660, where towing and storage are reasonably necessary to protect the vehicle from further loss, the insurer shall pay reasonable towing and storage charges incurred by the claimant. The insurer shall provide reasonable notice to the claimant before terminating payment for storage charges, so that the claimant has time to remove the vehicle from storage. This subsection shall also apply to a third party claim filed under automobile liability coverage as defined in California Insurance Code section 660, however, payment to a third party claimant may be prorated based upon the comparative fault of the parties.

Note: Authority cited: Sections 790.10, 12921 and 12926, Insurance Code; Section 3333, Civil Code; and Sections 11152 and 11342.2, Government Code. Reference: Sections 758.5,
§ 2695.85. Auto Body Repair Consumer Bill of Rights.

(a) Every insurer that issues automobile liability or collision insurance policies shall provide the named insured(s) with an Auto Body Repair Consumer Bill of Rights either at the time of application for an automobile insurance policy, at the time a policy is issued, or following an accident or loss that is reported to the insurer. If the insurer provides the insured with an electronic copy of a policy, the bill of rights may also be transmitted electronically. If the insurer provides the bill of rights following an accident or loss, the insurer shall also provide the bill of rights to the particular insured filing the insurance claim. If the insurer provides the bill of rights at the time of application or policy issuance, all named insureds that have not previously received the bill of rights shall be provided with a copy upon renewal of the policy.

(b) The requirements set forth in subsection 2695.85(a), above, shall apply to all automobile liability and collision insurance policies issued in California including commercial automobile, private passenger automobile, and motorcycle insurance policies.

(c) The Auto Body Repair Consumer Bill of Rights shall be a separate standardized document and plainly printed in no less than ten-point type. An insurer may distribute the form using its own letterhead, but the language of the Auto Body Repair Consumer Bill of Rights shall be developed by the California Department of Insurance and shall read as follows:

AUTO BODY REPAIR CONSUMER BILL OF RIGHTS

A CONSUMER IS ENTITLED TO:

1. SELECT THE AUTO BODY REPAIR SHOP TO REPAIR AUTO BODY DAMAGE COVERED BY THE INSURANCE COMPANY. AN INSURANCE COMPANY SHALL NOT REQUIRE THE REPAIRS TO BE DONE AT A SPECIFIC AUTO BODY REPAIR SHOP.

2. AN ITEMIZED WRITTEN ESTIMATE FOR AUTO BODY REPAIRS AND, UPON COMPLETION OF REPAIRS, A DETAILED INVOICE. THE ESTIMATE AND THE INVOICE MUST INCLUDE AN ITEMIZED LIST OF PARTS AND LABOR ALONG WITH THE TOTAL PRICE FOR THE WORK PERFORMED. THE ESTIMATE AND INVOICE MUST ALSO IDENTIFY ALL PARTS AS NEW, USED, AFTERMARKET, RECONDITIONED, OR REBUILT.

3. BE INFORMED ABOUT COVERAGE FOR TOWING AND STORAGE SERVICES.
4. BE INFORMED ABOUT THE EXTENT OF COVERAGE, IF ANY, FOR A REPLACEMENT RENTAL VEHICLE WHILE A DAMAGED VEHICLE IS BEING REPAIRED.

5. BE INFORMED OF WHERE TO REPORT SUSPECTED FRAUD OR OTHER COMPLAINTS AND CONCERNS ABOUT AUTO BODY REPAIRS.

COMPLAINTS WITHIN THE JURISDICTION OF THE BUREAU OF AUTOMOTIVE REPAIR
Complaints concerning the repair of a vehicle by an auto body repair shop should be directed to:

Toll Free (800) 952-5210
California Department of Consumer Affairs Bureau of Automotive Repair 10240 Systems Parkway Sacramento, CA 95827

The Bureau of Automotive Repair can also accept complaints over its web site at: www.autorepair.ca.gov

COMPLAINTS WITHIN THE JURISDICTION OF THE CALIFORNIA INSURANCE COMMISSIONER

Any concerns regarding how an auto insurance claim is being handled should be submitted to the California Department of Insurance at:

(800) 927-HELP or (213) 897-8921 California Department of Insurance Consumer Services Division 300 South Spring Street Los Angeles, CA 90013

The California Department of Insurance can also accept complaints over its web site at: www.insurance.ca.gov

Note: Authority cited: Sections 790.10, 1874.85 and 1874.87, Insurance Code. Reference: Sections 790.03(c), 790.03(h)(3) and 1874.87, Insurance Code; Sections 9884.8 and 9884.9, Business and Professions Code; and California Code of Regulations, Title 10, Chapter 5, Subchapter 7.5, Section 2695.8(j).


(a) When a residential or commercial property insurance policy provides for the adjustment and settlement of first party losses based on replacement cost, the following standards apply:

(1) When a loss requires repair or replacement of an item or part, any consequential physical damage incurred in making the repair or replacement not otherwise excluded by the policy shall be included in the loss. The insured shall not have to pay for depreciation nor any other cost except for the applicable deductible.

(2) When a loss requires replacement of items and the replaced items do not match in quality, color or size, the insurer shall replace all items in the damaged area so as to conform to a reasonably uniform appearance.

(b) No insurer shall require that the insured have the property repaired by a specific individual or entity.

(c) No insurer shall suggest or recommend that the insured have the property repaired by a
specific individual or entity unless:

(1) the referral is expressly requested by the claimant; or

(2) the claimant has been informed in writing of the right to select a repair individual or entity and, if the claimant accepts the suggestion or recommendation, the insurer shall cause the damaged property to be restored to no less than its condition prior to the loss and repaired in a manner which meets accepted trade standards for good and workmanlike construction at no additional cost to the claimant other than as stated in the policy or as otherwise allowed by these regulations.

(d) If losses are settled on the basis of a written scope and/or estimate prepared by or for the insurer, the insurer shall supply the claimant with a copy of each document upon which the settlement is based. The estimate prepared by or for the insurer shall be in accordance with applicable policy provisions, of an amount which will restore the damaged property to no less than its condition prior to the loss and which will allow for repairs to be made in a manner which meets accepted trade standards for good and workmanlike construction. The insurer shall take reasonable steps to verify that the repair or rebuilding costs utilized by the insurer or its claims agents are accurate and representative of costs in the local market area. If the claimant subsequently contends, based upon a written estimate which he or she obtains, that necessary repairs will exceed the written estimate prepared by or for the insurer, the insurer shall:

(1) pay the difference between its written estimate and a higher estimate obtained by the claimant; or,

(2) if requested by the claimant, promptly provide the claimant with the name of at least one repair individual or entity that will make the repairs for the amount of the written estimate. The insurer shall cause the damaged property to be restored to no less than its condition prior to the loss and which will allow for repairs in a manner which meets accepted trade standards for good and workmanlike construction at no additional cost to the claimant other than as stated in the policy or as otherwise allowed by these regulations; or,

(3) reasonably adjust any written estimates prepared by the repair individual or entity of the insured’s choice and provide a copy of the adjusted estimate to the claimant.

(e) Once the appraisal provision under an insurance policy is invoked, the appraisal process shall not include any legal proceeding or procedure not specified under California Insurance Code Section 2071. Nothing herein is intended to preclude separate legal proceedings on issues unrelated to the appraisal process.

(f) When the amount claimed is adjusted because of betterment, depreciation, or salvage, all justification for the adjustment shall be contained in the claim file. Any adjustments shall be discernable, measurable, itemized, and specified as to dollar amount, and shall accurately reflect the value of the betterment, depreciation, or salvage. Any adjustments for betterment or depreciation shall reflect a measurable difference in market value attributable to the condition and age of the property and apply only to property normally subject to repair and
replacement during the useful life of the property. The basis for any adjustment shall be fully explained to the claimant in writing.

(1) Under a policy, subject to California Insurance Code Section 2071, where the insurer is required to pay the expense of repairing, rebuilding or replacing the property destroyed or damaged with other of like kind and quality, the measure of recovery is determined by the actual cash value of the damaged or destroyed property, as set forth in California Insurance Code Section 2051. Except for the intrinsic labor costs that are included in the cost of manufactured materials or goods, the expense of labor necessary to repair, rebuild or replace covered property is not a component of physical depreciation and shall not be subject to depreciation or betterment.

Note: Authority cited: Sections 790.10, 2051, 2051.5, 2071, 12921 and 12926, Insurance Code; Section 7109, Business and Professions Code; and Sections 11152 and 11342.2, Government Code. Reference: Sections 790.03(h)(3), (5) and (7), Insurance Code.

§ 2695.10. Additional Standards Applicable to Surety Insurance.

(a) No insurer shall base or vary its claims settlement practices, or its standard of scrutiny and review, upon the claimant’s age, gender, income, religion, language, sexual orientation, ancestry, national origin, or physical disability, or upon the territory of the property or person insured.

(b) As soon as possible, but in no event later than forty (40) calendar days after receipt by the insurer of proof of claim, and provided the claim is not in litigation or arbitration, the insurer shall accept or deny the claim, in whole or in part, and affirm or deny liability. Every insurer that denies or rejects a claim in whole or in part, or disputes liability or damages, shall provide to the claimant a written statement listing all bases for such rejection or denial, and the factual and legal bases for each reason given for each rejection or denial, which are within the insurer’s knowledge. If an insurer’s denial of a claim in whole or in part is based on a specific statute or specific bond provisions, the denial shall include reference thereto and provide an explanation of the application of the statute or bond provision to the claim. Written notification pursuant to this subsection shall also include a notification that the claimant may have the matter reviewed by the California Department of Insurance and shall provide the address and telephone number of the unit of the Department which reviews complaints regarding claims practices.

(1) A principal’s absence, non-cooperation, or failure to meet the bonded obligation shall not excuse unreasonable delay by the insurer in determining whether a claim should be accepted or denied.

(2) While an insurer may consider all information provided by a principal, absent reasonable factual and/or legal bases for denying a claim, no insurer shall deny a claim based solely upon a principal’s protest of a claim or denial of liability for a claim.

(c) In the event an insurer requires more time than is allotted in subsection 2695.10(b) to
determine whether a claim should be accepted and/or denied, in whole or in part, the insurer shall provide the claimant with written notice of the need for such additional time within the time specified in subsection 2695.10(b). Such written notice shall specify the reasons for the need for such additional time, including specification of any additional information the insurer requires in order to make such determination. The insurer shall provide the claimant with written notice as to the continuing reasons for the insurer’s inability to make such a determination. Except in cases where extraordinary circumstances are present which materially affect the insurer’s ability to comply, such written notice shall be provided within 30 calendar days of the date of the initial notification, and every 30 calendar days thereafter until such determination is made or notice of legal action is received. If the determination cannot be made until some event, process, or third party determination is made, then the insurer shall comply with this requirement by advising the claimant of the situation and provide an estimate as to when the determination can be made.

(d) No insurer shall fail to pursue diligently an investigation of a claim, or persist in seeking information not reasonably required for or material to resolution of a claim dispute.

(e) No insurer shall deny a claim upon information obtained in a telephone conversation or personal interview with any source unless the telephone conversation or personal interview is documented in the claim file pursuant to the provisions of section 2695.3.

(f) Where the claim is to be settled by payment, and where neither the claim nor the amount is in dispute, such payment shall be tendered (1) within 15 calendar days following affirmation of liability where the insurer does not require the claimant to execute a release, or (2) within 15 calendar days following the insurer’s receipt of a release properly executed by the claimant, where such release is required by the insurer. Such release shall be provided to the claimant within ten (10) calendar days following affirmation of liability. Where multiple claimants are involved, payment shall be made pursuant to this subsection, provided such payment shall not increase the insurer’s liability, or impair the rights of other claimants under the bond.

(g) Except where a claim has been settled by payment, every insurer shall provide written notice of any statute of limitations or other time period requirement upon which the insurer may rely to deny a claim. Such notice shall be given to the claimant no less than sixty (60) days prior to the expiration date. If notice of claim is first received by the insurer within sixty (60) days of the expiration date and such date is known to the insurer, then notice of the expiration date must be given to the claimant immediately. This subsection shall not apply to a claimant represented by counsel on the claim matter or to a claim already time barred when first received by the insurer.

(h) No insurer shall attempt to settle a claim by making a settlement offer that is unreasonably low. The Commissioner shall consider any admissible evidence offered regarding the following factors in determining whether or not a settlement offer is unreasonably low:

(1) the extent to which the insurer considered evidence submitted by the claimant to support the value of the claim;

(2) the extent to which the insurer considered legal authority or evidence made known to it
or reasonably available;

(3) the procedures used by the insurer in determining the dollar amount of damages;

(4) any other credible evidence presented to the Commissioner that demonstrates that the final amount offered by the insurer in settlement of a claim is below the amount that a reasonable person with knowledge of the facts and circumstances would have offered in settlement of the claim.

Note: Authority cited: Sections 790.10, 12921, 12921.1 and 12926, Insurance Code. Reference: Sections 790.03(h)(3), (4) and (15) and 12921.3, Insurance Code; and Section 2807, Civil Code.

§ 2695.11. Additional Standards Applicable to Life and Disability Insurance Claims.

(a) No insurer shall seek reimbursement of an overpayment or withhold any portion of any benefit payable as a result of a claim on the basis that the sum withheld or reimbursement sought is an adjustment or correction for an overpayment made under the same policy unless:

(1) the insurer’s files contain clear, documented evidence of an overpayment and written authorization from the insured or assignee, if applicable, permitting the reimbursement or withholding procedure, or

(2) the insurer’s files contain clear, documented evidence pursuant to section 2695.3 of all of the following:

(A) The overpayment was erroneous under the provisions of the policy.

(B) The error which resulted in the payment is not a mistake of the law.

(C) The insurer notifies the insured within six (6) months of the date of the error, except that in instances of error prompted by representations or nondisclosure of claimants or third parties, the insurer notifies the insured within fifteen (15) calendar days after the date of discovery of such error. For the purpose of this subsection, the date of the error shall be the day on which the draft for benefits is issued.

(D) Such notice states clearly the cause of the error and states the amount of the overpayment.

(E) The procedure set forth above in (a)(2)(A) through (D) above may not be used if the overpayment is the subject of a reasonable dispute as to facts.

(b) With each claim payment, the insurer shall provide to the claimant and assignee, if any,
an explanation of benefits which shall include, if applicable, the name of the provider or services covered, dates of service, and a clear explanation of the computation of benefits.

(c) An insurer may not impose a penalty upon any insured for noncompliance with insurer requirements for precertification of benefits unless such penalties are specifically and clearly set forth in writing in the policy or certificate of insurance.

(d) An insurer that contests a claim under California Insurance Code Section 10123.13 shall subsequently affirm or deny the claim within thirty (30) calendar days from the original notification. In the event an insurer requires additional time to affirm or deny the claim, it shall notify the claimant and assignee in writing. This written notice shall specify any additional information the insurer requires in order to make a determination and shall state any continuing reasons for the insurer's inability to make a determination. This notice shall be given within thirty (30) calendar days of the notice (required under Insurance Code Section 10123.13) that the claim is being contested and every thirty (30) calendar days thereafter until a determination is made or legal action is served. If the determination cannot be made until some future event occurs, the insurer shall comply with this continuing notice requirement by advising the claimant and assignee of the situation and providing an estimate as to when the determination can be made.

(e) When a policy requires preauthorization of non-emergency medical services, the preauthorization must be given immediately but in no event more than five (5) calendar days after the request for preauthorization. The preauthorization shall be communicated or confirmed in writing to the insured and the medical service provider, and shall explain the scope of the preauthorization and whether the preauthorization is or is not a guarantee of acceptance of the claim. In the event the preauthorization is denied, the reason(s) for the denial shall be communicated in writing to the insured and the medical service provider.

(f) No preauthorization shall be required by an insurer for emergency medical services.

(g) An insurer shall reimburse the insured or medical service provider for reasonable expenses incurred in copying medical records requested by the insurer.

Note: Authority cited: Sections 790.10, 12921 and 12926, Insurance Code; and Sections 11342.2 and 11152, Government Code. Reference: Sections 790.03(h)(1), (2), (3), (5) and (13) and 10123.13, Insurance Code.

§ 2695.12. Penalties.

(a) In determining whether to assess penalties and if so the appropriate amount to be assessed, the Commissioner shall consider admissible evidence on the following:

(1) the existence of extraordinary circumstances;

(2) whether the licensee has a good faith and reasonable basis to believe that the claim or
claims are fraudulent or otherwise in violation of applicable law and the licensee has com-
plied with the provisions of Section 1872.4 of the California Insurance Code;

(3) the complexity of the claims involved;

(4) gross exaggeration of the value of the property or severity of the injury, or amount of
damages incurred;

(5) substantial mischaracterization of the circumstances surrounding the loss or the alleged
default of the principal;

(6) secreting of property which has been claimed as lost or destroyed.

(7) the relative number of claims where the noncomplying act(s) are found to exist, the total
number of claims handled by the licensee and the total number of claims reviewed by the
Department during the relevant time period;

(8) whether the licensee has taken remedial measures with respect to the noncomplying
act(s);

(9) the existence or nonexistence of previous violations by the licensee;

(10) the degree of harm occasioned by the noncompliance;

(11) whether, under the totality of circumstances, the licensee made a good faith attempt to
comply with the provisions of this subchapter;

(12) the frequency of occurrence and/or severity of the detriment to the public caused by the
violation of a particular subsection of this subchapter;

(13) whether the licensee’s management was aware of facts that apprised or should have ap-
prised the licensee of the act(s) and the licensee failed to take any remedial measures; and

(14) the licensee’s reasonable mistakes or opinions as to valuation of property, losses or
damages.

(b) This section shall not bar, obstruct or restrict any right to administrative due process
an insurer may be afforded under California Insurance Code Sections 790.05, 790.06, and
790.07.

Note: Authority cited: Sections 704, 780-784, 790.035, 790.07, 790.08, 790.09, 790.10,
1011, 1065, 1872.4, 11690, 12340-12417, inclusive, 12921, 12926 and 12928.6, Insurance
Code; and Sections 11152 and 11342.2, Government Code. Reference: Sections 790.03(h),
790.035(a), 790.04, 790.05, 790.06, 790.08 and 790.10, Insurance Code.

§ 2695.13. Severability.
If any provision or clause of this rule or the application thereof to any person or situation is held invalid, such invalidity shall not affect any other provision or application of this rule which can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.

Note: Authority cited: Sections 790.10, 12340-12417, inclusive, 12921 and 12926, Insurance Code; and Sections 11342.2 and 11152, Government Code. Reference: Section 790.03(h), Insurance Code.

§ 2695.14. Compliance Date.

(a) Any amendments to these regulations shall be complied with within ninety (90) calendar days after they are filed with the Secretary of State.

(b) Prior to the compliance date of these regulations, licensees shall, pursuant to Section 2695.6, adopt and communicate to their claims agents standards for the prompt investigation and processing of claims, and provide training and instruction on these regulations.

(c) These regulations shall apply to any claims handling that takes place on or after the compliance date set forth under subsection 2695.14(a).

Note: Authority cited: Sections 790.10, 12921 and 12926, Insurance Code; and Section 11343.4, Government Code. Reference: Section 790.03(h), Insurance Code.
Annual Certification For Claims Agents  
Re Fair Claims Settlement Practices Regulations  

Section 2695.6(B)/2695.2(D)  

Pursuant to California Code of Regulations, Title 10, Chapter 5, Subchapter 7.5 Fair Claims Settlement Practices Regulations, Section 2695.6 Training and Certification, I _____________________ [name], declare that I have successfully completed a training seminar which explains the regulations in the above subchapter.

I declare under penalty of perjury pursuant to the laws of the State of California that the foregoing is true and correct.

Dated: ___________________________  
By: [name]  
___________________________
Licensee Annual Certification  
Re Fair Claims Settlement Practices Regulations

Section 2695.6(B)

Pursuant to California Code of Regulations, Title 10, Chapter 5, Subchapter 7.5 Fair Claims Settlement Practices Regulations, Section 2695.6 Training and Certification,

I, __________________ [name], ______________________ [title] of ______________________________________________ [company/licensee], declare that

1) licensee has provided thorough and adequate training regarding the regulations and any revisions thereto to all claims agents [§2695.6(b)/2695.2(d)];

2) licensee’s claims adjusting manual contains a copy of the Fair Claims Settlement Practices Regulations and all amendments thereto [§2695.6(b)(2)(A)]; and

3) clear written instructions regarding the procedures to be followed to effect proper compliance with the Fair Claims Settlement Practices Regulations were provided to all claims agents [§2695.6(b)(2)(B)].

4) to the extent any insurance adjuster, as defined in Insurance Code §14021, has not certified in writing, under penalty of perjury, that he or she has read and understands these regulations and all amendments thereto or has successfully completed a training seminar which explains these regulations, then licensee has provided training to said insurance adjusters regarding the Fair Claims Settlement Practices Regulations [§2695.6(b)(3)].

A copy of this certification shall be maintained at all times at the principal place of business of licensee, to be provided to the Commissioner only upon request [§2695.6(b)(4)].

I declare under penalty of perjury pursuant to the laws of the State of California that the foregoing is true and correct.

Dated: ___________________________  By: [name]
__________________________________
Insurance Adjuster Annual Certification
Re Fair Claims Settlement Practices Regulations

Section 2695.6(B)(3)

Pursuant to California Code of Regulations, Title 10, Chapter 5, Subchapter 7.5 Fair Claims Settlement Practices Regulations, Section 2695.6 Training and Certification,

I, ___________________ [name], declare that

____ I have read and understood the regulations contained in the above subchapter and all amendments thereto.

____ I have successfully completed a training seminar which explains the regulations in the above subchapter.

I declare under penalty of perjury pursuant to the laws of the State of California that the foregoing is true and correct.

Dated: ___________________________ By: [name]

___________________________
Surety Initial Acknowledgment Letter Provisions

The following provides suggested language to be included in the initial acknowledgment letter to claimants for various California surety bonds to comply with California Code of Regulations, title 10, chapter 5, subchapter 7.5, section 2695.10, subdivision (g), which provides:

Except where a claim has been settled by payment, every insurer shall provide written notice of any statute of limitations or other time period requirement upon which the insurer may rely to deny a claim. Such notice shall be given to the claimant no less than sixty (60) days prior to the expiration date. If notice of claim is first received by the insurer within sixty (60) days of the expiration date and such date is known to the insurer, then notice of the expiration date must be given to the claimant immediately. This subsection shall not apply to a claimant represented by counsel on the claim matter or to a claim already time barred when first received by the insurer.

CAVEAT: The surety must review both the bond and the underlying bonded contract, particularly if it is a private works or common law bond, to determine if there are other time limits that the surety must disclose to the claimant as well. Should there exist additional time limits, the surety should consider including a statement, such as: “Paragraph ___ of the bond/bonded contract sets forth additional time limits that may apply to your claim.”

CALIFORNIA PUBLIC WORKS PAYMENT BOND
California Civil Code section 9560 sets forth the time limit for the prerequisites for claims against California Public Works Payment Bonds.

California Civil Code sections 9558 and 9356 define the statute of limitations applicable to claims on California Public Works Payment Bonds.

CALIFORNIA PUBLIC WORKS PERFORMANCE BOND
California Code of Civil Procedure sections 337, 337.1, 337.15 or 338 may apply as the statute of limitation applicable to claims on California Public Works Performance Bonds.

CALIFORNIA PUBLIC WORKS STOP PAYMENT NOTICE RELEASE BOND
California Civil Code section 9500 sets forth the time limit for the prerequisites for claims against California Public Works Stop Payment Notices that should apply to Release Bonds as well.

California Code of Civil Procedures section 338 is the statute of limitations applicable to claims on California Public Works Stop Payment Notice Release Bonds.

CALIFORNIA PRIVATE WORKS PAYMENT BOND
California Civil Code section 8612 sets forth the time limit for the prerequisites for claims against California Private Works Payment Bonds.
California Code of Civil Procedure section 337 and California Civil Code sections 8609 or 8610 may apply as the statute of limitations applicable to claims on California Private Works Payment Bonds.

**AMERICAN INSTITUTE OF ARCHITECTS A312 PAYMENT BOND**

Section 5 sets forth the time limit for the prerequisites for claims against American Institute of Architects A312 Payment Bonds.

Section 12 sets forth the time limit applicable to legal proceedings against American Institute of Architects A312 Payment Bonds. (*The one year limitation period set forth may not be enforceable pursuant to Civil Code section 8609 and 8610 and California Code of Civil Procedure section 337 may apply.)*

**CALIFORNIA PRIVATE WORKS PERFORMANCE BOND**

California Code of Civil Procedure sections 337, 337.1 or 337.15 may apply as the statute of limitation applicable to claims on California Private Works Performance Bonds.

If the performance bond contains a contractual limitations period:

Paragraph ___ of the bond sets forth a contractual limitations period applicable to a claim on this California Private Works Performance Bond.

**AMERICAN INSTITUTE OF ARCHITECTS A312 PERFORMANCE BOND**

Paragraph 9 sets for the time limit applicable to legal proceedings against American Institute of Architects A312 Performance Bonds.

**FEDERAL MILLER ACT PAYMENT BOND**

40 United States Code section 3133(b)(2) sets forth the time limit for the prerequisites for claims against Federal Miller Act Payment Bonds.

40 United States Code section 3133(b)(4) is the statute of limitations applicable to claims on Federal Miller Act Payment Bonds.

**FEDERAL MILLER ACT PERFORMANCE BOND**

28 United States Code section 2415(a) is the statute of limitations applicable to claims on Federal Miller Act Performance Bonds.

**CALIFORNIA PRIVATE WORKS MECHANIC’S LIEN RELEASE BOND**

California Civil Code sections 8410, 8412, and 8414 set forth the time limit for the prerequisites for claims against California Private Works Mechanic’s Liens.

California Civil Code section 8424(d) is the statute of limitations applicable to claims on California Private Works Mechanic’s Lien Release Bonds.
CALIFORNIA PRIVATE WORKS STOP PAYMENT NOTICE RELEASE BOND
California Civil Code section 8508 sets forth the time limit for the **prerequisites** for claims against California Private Works Stop Payment Notices that should apply to Release Bonds as well.

California Code of Civil Procedure sections 337 or 338 may be the statute of limitations applicable to claims on California Private Works Stop Payment Notice Release Bonds.

CALIFORNIA CONTRACTOR’S LICENSE BOND
California Business and Professions Code section 7071.11 is the statute of limitations applicable to claims on California Contractor’s License Bonds.

CALIFORNIA VEHICLE DEALER’S BOND
California Code of Civil Procedure sections 337 or 338 may apply as the statute of limitations applicable to claims on California Vehicle Dealer’s Bonds.

CALIFORNIA NOTARY PUBLIC BOND
California Code of Civil Procedure section 338 is the statute of limitations applicable to claims on California Notary Public Bonds.
About Sedgwick LLP

Sedgwick enjoys an international reputation as a trial and advocacy law firm that is based on our record of winning cases and providing sophisticated, result-oriented strategies. Founded in 1933 as a three-person firm in San Francisco, Sedgwick now has more than 350 attorneys in offices in Austin, Chicago, Dallas, Fort Lauderdale, Houston, London, Los Angeles, Newark (New Jersey), New York, Orange County (California), Paris, San Francisco, Seattle and Washington D.C. and an associated office in Bermuda. The firm’s clients include Fortune 500 companies and international businesses.

Sedgwick attorneys are willing and able to try and to win cases, whether in the courtroom, in arbitration proceedings, or in mediations. Our lawyers are adept at managing complex litigation filed in a variety of jurisdictions, from local to national to international. The firm defends and manages mass tort, environmental, class action, multidistrict and market share litigation as national and regional trial counsel, and frequently serves as national, regional and lead liaison counsel for leading international insurance companies as well as pharmaceutical, automobile, tobacco, and medical device manufacturers.

The most complex and high-stakes legal challenges facing the insurance industry demand the highest level of expertise and commitment, delivered by a coordinated team across all areas of insurance law. Sedgwick’s insurance practice is organized by substantive discipline with attorneys from each of Sedgwick’s offices in the United States, Europe and our affiliated office in Bermuda.

Together, the firm’s insurance-related practices comprise one of the largest international teams of trial attorneys, coverage advisors, and consultants regarding the complex business of insurance dedicated to the institutional concerns and success of the insurance industry.

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- Insurance Regulatory
- Life, Health & Disability
- Managed Care
- Policy Drafting/Advice
- Professional Liability
- Property Coverage
- Reinsurance
- Surety
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