Ohio Administrative Code

Rule 3901-1-07 Unfair trade practices.

Effective: April 5, 2007

(A) Authority

Section 3901.041 of the Revised Code provides that the superintendent of insurance shall adopt, amend, and rescind rules and make adjudications necessary to discharge his duties and exercise his powers under Title 39 of the Revised Code.

(B) Purpose

Sections 3901.20 and 3901.21 of the Revised Code respectively prohibit unfair or deceptive practices in the business of insurance and define certain acts or practices as unfair or deceptive. Section 3901.21 of the Revised Code also provides that the enumeration of specific unfair or deceptive acts or practices in the business of insurance is not exclusive or restrictive or intended to limit the powers of the superintendent of insurance to adopt rules to implement that section. The purpose of this rule is to define certain additional unfair trade practices and to set forth required procedures in connection therewith.

(C) Defined unfair practices

It shall be deemed an unfair or deceptive practice to commit or perform with such frequency as to indicate a general business practice any of the following:

(1) Knowingly mispresenting to claimants pertinent facts or policy provisions relating to coverage at issue;

(a) Misrepresenting a pertinent policy provision by making any payment, settlement, or offer of first party benefits, which, without explanation, does not include all amounts which should be included according to the claim filed by the first party claimant and investigated by the insurer;

(b) Denying a claim on the grounds of a specific policy provision, condition, or exclusion without reference to such provision, condition, or exclusion;

(2) Failing to acknowledge pertinent communications with respect to claims arising under insurance policies in writing, or by other means so long as an appropriate notation is made in the claim file of the insurer, within fifteen days of receiving notice of a claim in writing or otherwise;

(3) Failing to make an appropriate reply within twenty-one days of all other pertinent communications and/or any inquiries of the department of insurance respecting a claim;

(4) Failing to adopt and implement reasonable procedures to commence an investigation of any claim filed by either a first party or third party claimant, or by such claimant's authorized representative, within twenty-one days of receipt of notice of claim;

(5) Failing to mail or furnish claimant or the claimant's authorized representative, a notification of all items, statements and forms, if any, which the insurer reasonably believes will be required of such claimant, within fifteen days of receiving notice of claim, unless the insurer, based on the information then in its possession does not yet know all such requirements, then such notification shall be sent, within a reasonable time;

(6) Not offering first party or third party claimants, or their authorized representatives who have made claims which are fair and reasonable and in which liability has become reasonably clear, amounts which are fair and reasonable as shown by the insurer's investigation of the claim, providing the amounts so offered are within policy limits and in accordance with the policy provisions;

(7) Compelling insureds to institute suits to recover amounts due under its policies by offering substantially less then the amounts ultimately recovered in suits brought by them when such insureds have made claims for amounts reasonably similar to the amounts ultimately recovered;

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

(9) Attempting settlement or compromise of claims on the basis of applications which were altered without notice to, or knowledge, or consent of insureds;

(10) Attempting to settle or compromise claims for less than the amount which the insureds had been led reasonably to believe they were entitled to, by written or printed advertising material accompanying or made part of an application;

(11) Attempting to delay the investigation or payment of claims by requiring an insured and his physician 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 advise the first party claimant or the claimant's authorized representative, in writing or by other means so long as an appropriate notation is made in the claim file of the insurer, of the acceptance or rejection of the claim, within twenty-one days after receipt by the insurer of a properly executed proof of loss;

(a) Failing to notify such claimant or the claimant's authorized representative, within twenty-one days after receipt of such proof of loss, that the insurer needs more time to determine whether the claim should be accepted or rejected;

(b) Failing to send a letter to such claimant or, the claimant's authorized representative, stating the need for further time to investigate the claim, if such claim remains unsettled ninety days from the date of the initial letter setting forth the need for further time to investigate;

(c) Failing to send to such claimant or authorized representative every ninety days after the first ninety-day claim investigation period, a letter setting forth the reasons additional time is needed for investigation, unless the delay is caused by factors beyond the insurer's control;

(13) Failing to advise such claimant or claimant's authorized representative, of the amount offered, if such claim is accepted in whole or in part;

(14) Refusing payments of claims solely on the basis of the insured's request to do so without making an independent evaluation of the insured's liability based upon all available information;

(15) Failing to adopt and implement reasonable standards for the proper handling of written communications, primarily expressing grievances, received by the insurer from insureds or claimants;

(16) Failing to pay any amount finally agreed upon in settlement of all or part of any claim or authorized repairs to be made upon final agreement not later than five days from the receipt of such agreement by the insurer at the place from which the payment or authorization is to be made or from the date of the performance by the claimant of any condition set by such agreement, whichever is later.

(17) For purposes of this rule, the following definitions shall apply;

(a) "Investigation" shall mean all activities of the company related directly or indirectly to the determining of liabilities under the coverages afforded by the policy. This shall include, but not be limited to, a bona fide effort to contact all insureds and claimants within a reasonable period after notification of loss. Evidence of a bona fide effort must be maintained in the file. The investigation shall be deemed concluded upon the company's affirmation or denial of liability.

(b) "Notice of Claim" as applied to an insurer shall include notification given to an agent of an insurer.

(c) "Settlement of claims" shall mean all activities of the company related directly or indirectly to the determination of the extent of damages due under coverages afforded by the policy. This shall include, but not be limited to, the requiring or preparing of repair estimates.

(d) "Days" means calendar days. However, when the last day of a time limit stated in this rule falls on a Saturday, Sunday or holiday, the time limit is extended to the next immediate following day that is not a Saturday, Sunday or holiday.

(D) Severability

If any paragraph, term, or provision of this rule be adjudged invalid for any reason, such judgment

shall not affect, impair, or invalidate any other paragraph, term, or provision of this rule, but the remaining paragraphs, terms, and provisions shall be in and continue in full force and effect.