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Rulemaking Hearing Rule(s) Filing Form

Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing (Tenn. Code Ann. § 4-5-205).

Pursuant to Tenn. Code Ann. § 4-5-229, any new fee or fee increase promulgated by state agency rule shall take effect on July 1, following the expiration of the ninety (90) day period as provided in § 4-5-207. This section shall not apply to rules that implement new fees or fee increases that are promulgated as emergency rules pursuant to § 4-5-208(a) and to subsequent rules that make permanent such emergency rules, as amended during the rulemaking process. In addition, this section shall not apply to state agencies that did not, during the preceding two (2) fiscal years, collect fees in an amount sufficient to pay the cost of operating the board, commission or entity in accordance with § 4-29-121(b).

Agency/Board/Commission:	Department of Commerce and Insurance
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Revision Type (check all that apply):

___ Amendment
_X_ New
___ Repeal

Rule(s) (**ALL** chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables to accommodate multiple chapters. Please make sure that **ALL** new rule and repealed rule numbers are listed in the chart below. Please enter only **ONE** Rule Number/Rule Title per row)

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New

Chapter 0780-01-05
Unfair Claims Settlement Practices

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0780-01-05-.01 Purpose.

The purpose of this Chapter is to set forth minimum standards for the investigation and disposition of claims arising under contracts or certificates of insurance issued to residents of the state. It is not intended to cover claims involving workers' compensation or health care. The various provisions of this Chapter are intended to define procedures and practices which constitute unfair claims practices as determined by the commissioner. Nothing herein shall be construed either to create or to imply a private cause of action for violation of this Chapter.

Authority: T.C.A. §§ 56-2-301, 56-8-101 through 56-8-120, 56-8-101(c), 56-8-105, 56-8-108, and 56-8-110.

0780-01-05-.02 Scope.

This Chapter applies to all insurers or persons subject to title 56, chapter 8, part 1, that are authorized to sell, transact, or are otherwise engaged in the business of insurance in this state. Specifically, rules 0780-01-05-.06 through .10 only apply to property and casualty insurers doing business in this state. Rule 0780-01-05-.11 only applies to life insurers doing business in this state.

Authority: T.C.A. §§ 56-2-301, 56-8-101 through 56-8-120, 56-8-108, and 56-8-110.

0780-01-05-.03 Authority.

This Chapter is issued pursuant to the authority vested in the commissioner pursuant to T.C.A. §§ 56-8-108 and 56-8-110, the Tennessee Unfair Trade Practices and Unfair Claims Settlement Act of 2009,

T.C.A. title 56, chapter 8, part 1, and other authority conferred by the insurance laws of Tennessee to regulate lines of insurance.

Authority: T.C.A. §§ 56-2-301, 56-8-101 through 56-8-120, 56-8-108, and 56-8-110.

0780-01-05-.04 Definitions.

All definitions contained in the Tennessee Unfair Trade Practices and Unfair Claims Settlement Act of 2009, T.C.A. title 56, chapter 8, part 1, are hereby incorporated by reference. As otherwise used in this Chapter, the following definitions apply unless otherwise specifically defined herein:

(1) "Beneficiary" means the party entitled to receive the proceeds or benefits occurring under the policy of the insured;

(2) "Claim" means:

(a) 1. An oral, written, or electronic submission for payment that is filed by an insured, on behalf of an insured, or by a third party where the insurer accepts such claims, in accordance with the insurer's reasonable submission standards; and

2. Is sufficient to reasonably establish contractual liability for payment on the part of the insurer;

(b) For the purposes of T.C.A. § 56-8-105, a "claim" does not mean an inquiry by an insured as to the existence of coverage or how a potential claim may affect future premiums or renewability of coverage;

(3) "Claim file" means any retrievable electronic file, paper file, or combination of both, relative to a specific claim made by or on behalf of a claimant with an insurer;

(4) "Commissioner" means the commissioner of the department of commerce and insurance;

(5) "Days" means calendar days unless otherwise noted;

(6) "Department" means the department of commerce and insurance;

(7) "Documentation" or "to be documented" includes, but is not limited to, all pertinent communications, transactions, notes, work papers, claim forms, bills and explanation of benefits forms relative to the claim;

(8) "First party claimant" means an individual, corporation, association, partnership or other legal entity asserting a right to payment directly against an insurer under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by the policy or contract;

(9) "Inquiry" means any communication to an insurance company by an insured or by an insurance producer on behalf of an insured, regarding general terms and conditions of the insured's personal residential property policy, including a communication concerning whether an insured's personal residential property policy provides coverage for a type of event or the process for filing a claim;

(10) "Insurance producer" or "producer" means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance under title 56, chapter 6, part 1;

(11) "Investigation" means all activities of an insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy or insurance contract;

(12) "Notification of claim" or "notice of claim" means any notification, in writing or other means acceptable under the terms of an insurance policy, to an insurer or its producer by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim;

(13) "Personal residential property policy" means a homeowners insurance policy or a policy otherwise described in T.C.A. §§ 56-5-302(7)(A) and (B);

(14) "Proof of loss" means written proofs, such as claim forms, or other reasonable evidence of the claim that is required of insureds or beneficiaries submitting the claims;

(15) "Reasonable explanation" means information sufficient to enable the insured or beneficiary to compare the allowable benefits with policy provisions and determine whether proper payment has been made;

(16) "Third party claimant" means any person asserting a claim against any person under a policy or certificate of an insurer; and

(17) "Written communication" includes all correspondence, regardless of source or type, that is materially related to the handling of the claim. Written communication also includes electronic mail (email) when requested by the claimant and when accepted by the insurer. Written communication does not include any privileged communication that is prepared by an attorney employed or retained by an insurer, including, but not limited to, work product or legal opinions.

Authority: T.C.A. §§ 56-2-301, 56-5-302(7)(A) and (B), 56-6-102, 56-7-3403, 56-8-101 through 56-8-120, 56-8-102, 56-8-108, and 56-8-110.

0780-01-05-.05 File and Record Documentation.

Each insurer's claim files for policies or certificates are subject to examination by the commissioner or his or her duly appointed designees. To aid in such examination:

(1) The insurer shall maintain claim data that is accessible and retrievable for examination. An insurer shall be able to provide the claim number, line of coverage, date of loss, date of payment of the claim, date of denial or date closed without payment. This data must be available for all open and closed claim files for the current year and the five (5) preceding years.

(2) Documentation shall be contained in each claim file in order to permit reconstruction of the insurer's activities relative to each claim.

(3) Each relevant document within the claim file shall be noted as to date received, date processed, or date mailed.

(4) For those insurers that do not maintain hard copy files, claim files must be accessible from cathode ray tube (CRT), micrographics, magnetic tape, electronic databases, or other electronic storage formats, and be capable of duplication to hard copy.

Authority: T.C.A. §§ 56-1-103, 56-1-106, 56-1-408, 56-1-409, 56-1-410, 56-2-301, 56-8-101 through 56-8-120, 56-8-104(10), 56-8-107, 56-8-108, and 56-8-110.

0780-01-05-.06 Misrepresentation of Policy Provisions.

(1) No insurer shall fail to fully disclose, upon request, to first party claimants all pertinent benefits, coverages or other provisions of a policy or contract under which a claim is presented.

(2) No producer shall misrepresent to named insureds benefits, coverages or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim.

(3) A claim shall not be denied on the basis of failure to provide access to property unless provided for under the terms of the policy and documented in the claim file.

(4) No insurer shall deny a claim based upon the failure of a first party claimant to give written notice of loss within a specified time limit unless the written notice is a written policy condition.

(5) No insurer shall indicate to a first party claimant on a payment draft, check, or in any accompanying letter that said payment is "final" or "a release" of any claim unless the policy limit has been paid or there has been a compromise settlement agreed to by the first party claimant and the insurer as to coverage and amount payable under the contract.

(6) No insurer shall issue checks or drafts in partial settlement of a loss or claim under a specific coverage that contains language purporting to release the insurer or its insured from total liability.

Authority: T.C.A. §§ 56-2-301, 56-8-101 through 56-8-120, 56-8-104, 56-8-105, 56-8-108, and 56-8-110.

0780-01-05-.07 Failure to Acknowledge Pertinent Communications.

(1) Every insurer, upon receiving notification of a claim, shall, within thirty (30) days, acknowledge the receipt of such notice unless payment is made within that period of time. If an acknowledgement is made by means other than writing, an appropriate notation of the acknowledgement shall be made in the claim file of the insurer and dated.

(2) Pursuant to T.C.A. § 56-1-106, if the department makes a request for information from an insurer concerning a complaint filed against the insurer, the insurer must respond to the request within thirty (30) days from the date the request is received by the insurer.

(3) An appropriate reply shall be made within thirty (30) days on all other pertinent communications from a first party claimant which reasonably suggest that a response is expected.

(4) Every insurer, upon receiving notification of claim, shall promptly provide necessary claim forms, instructions and reasonable assistance so that first party claimants can comply with the policy conditions and the insurer's reasonable requirements. Compliance with this paragraph within thirty (30) days of notification of a claim shall constitute compliance with paragraph 0780-01-05-.07(1).

Authority: T.C.A. §§ 56-1-106, 56-2-301, 56-8-101 through 56-8-120, 56-8-105, 56-8-108, and 56-8-110.

0780-01-05-.08 Standards for Prompt, Fair and Equitable Settlements Applicable to Property and Casualty Insurers.

(1) Within sixty (60) days after receipt by the insurer of properly completed and executed proofs of loss and such information or documents required under the policy, the first party claimant shall be advised of the acceptance or denial of liability for the claim by the insurer. No insurer shall deny a claim without providing a basis for the denial. Upon request, any denial must be given to the first party claimant in writing and the claim file of the insurer shall contain documentation of the denial as required by rule 0780-01-05-.05.

(a) Where there is a reasonable basis supported by specific information available for review by the department that the first party claimant has fraudulently caused, contributed to, or misrepresented the loss, the insurer is relieved from the requirements of paragraph 0780-01-05-.08(1); provided, however, that the first party claimant shall be advised of the acceptance or denial of liability for the claim within a reasonable time for full investigation after receipt by the insurer of a properly completed and executed proof of loss.

(2) If the insurer needs more time to determine whether liability for a first party claim should be accepted or denied, it shall so notify the first party claimant within sixty (60) days after receipt of the proofs of loss and such information or documents required under the policy, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, sixty (60) days from the initial notification and every sixty (60) days thereafter, send to the first party claimant a letter setting forth the reasons additional time is needed for investigation.

(a) Where there is a reasonable basis supported by specific information available for review by the department for suspecting that the first party claimant has fraudulently caused, contributed to, or misrepresented the loss, the insurer is relieved from the requirements

of paragraph 0780-01-05-.08(2); provided, however, that the claimant shall be advised of the acceptance or denial of liability for the claim by the insurer within a reasonable time for full investigation after receipt by the insurer of a properly completed and executed proof of loss.

(3) The insurer shall, within thirty (30) days after concluding a coverage investigation, notify the first party claimant of the findings of the investigation. Paragraphs 0780-01-05-.08(1) and (2) shall apply at the time the notice of investigation closure is sent.

(4) Insurers shall not fail to settle first party claims on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions.

(5) Insurers shall give notice of an applicable statute of limitations to first party claimants at least thirty (30) days before the date on which such statute of limitations may expire.

(6) The insurer shall tender payment within thirty (30) days of affirmation of liability, if the amount of the claim is determined and not in dispute, unless the policyholder does not want payment within thirty (30) days.

(7) No insurer shall request or require any insured to submit to a polygraph examination unless authorized under the applicable insurance contracts and state law.

(8) If, after an insurer denies a claim in its entirety, the first party claimant objects in writing to such denial, the insurer shall notify the first party claimant in writing that he or she may file a complaint with the department, Consumer Insurance Services, 500 James Robertson Parkway, Nashville, Tennessee 37243, 1-800-342-4029, or may submit the complaint request for review electronically to that section's complaint link for insurance complaints, currently found at: https://tn.gov/commerce/topic/commerce-file-a-complaint.

(9) An insurer shall notify a policyholder of his or her right to choose a vendor to complete repairs of damages covered under the policy, unless use of a specified vendor is provided pursuant to the terms of the policy. If a notice is made by means other than writing, an appropriate notation of the notice shall be made in the claim file of the insurer and dated.

(10) No insurer shall cancel a personal residential property policy in effect for sixty (60) days or more, if the sole reason for the cancellation of the policy is that a claim is pending with the insurer.

(11) Pursuant to T.C.A. § 56-7-113, no insurance company shall increase a premium or cancel a personal residential property policy solely on the basis of an inquiry or inquiries by an insured regarding the insured's personal residential property policy or a loss under the policy.

Authority: T.C.A. §§ 56-2-201, 56-2-202, 56-2-301, 56-7-113, 56-8-101 through 56-8-120, 56-8-105, 56-8-108, and 56-8-110.

0780-01-05-.09 Standards for Prompt, Fair and Equitable Settlements Applicable to Automobile Insurance.

(1) When the insurance policy provides for the adjustment and settlement of first party automobile total losses on the basis of actual cash value or replacement with another of like kind and quality, one of the following methods shall apply at the discretion of the insurer:

(a) The insurer may elect to offer a replacement automobile that is at least comparable in that it will be by the same manufacturer, same or newer year, similar body style, similar options and mileage as the insured vehicle and in as good or better overall condition and available for inspection at a licensed dealer within a reasonable distance of the insured's residence. The insurer shall pay all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of the automobile, paid at no cost other than any deductible provided in the policy. The offer and any rejection thereof must be documented in the claim file.

(b) The insurer may elect a cash settlement based upon the actual cost, less any deductible provided in the policy, to purchase a comparable automobile including all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of a comparable automobile. Such cost may be derived from:

1. The cost of two or more comparable automobiles in the local market area when comparable automobiles are available or were available within the last ninety (90) days to consumers in the local market area; or

2. The cost of two (2) or more comparable automobiles in areas proximate to the local market area, including the closest major metropolitan areas within or without the state, that are available or were available within the last ninety (90) days to consumers when comparable automobiles are not available in the local market area pursuant to part 0780-01-05-.09(1)(b)1. above; or

3. One (1) of two (2) or more quotations obtained by the insurer from two (2) or more licensed dealers located within the local market area when the cost of comparable automobiles are not available pursuant to parts 0780-01-05-.09(1)(b)1. and (1)(b)2. above; or

4. Any source for determining statistically valid fair market values that meet all of the following criteria:

(i) The source shall give primary consideration to the values of vehicles in the local market area and may consider data on vehicles outside the area;

(ii) The source's database shall produce values for at least eighty-five percent (85%) of all makes and models for the last fifteen (15) model years, taking into account the values of all major options for such vehicles; and

(iii) The source shall produce fair market values based on current data available from the area surrounding the location where the insured vehicle was principally garaged or a necessary expansion of parameters (such as time and area) to assure statistical validity.

(c) When a first party claimant's automobile total loss is settled on a basis which deviates from the methods described in subparagraphs 0780-01-05-.09(1)(a) and (1)(b), the deviation must be supported by documentation giving particulars of the automobile condition. Any deductions from the cost, including deduction for salvage, must be as specific as reasonably possible, and specific and appropriate as to dollar amount, and shall be documented in the claim file as required by rule 0780-01-05-.05. The basis for the settlement shall be fully explained to the first party claimant.

(2) Insurers shall not require a first party claimant to travel an unreasonable distance either to inspect a replacement automobile, to obtain a repair estimate or to have the automobile repaired at a specific repair shop.

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

(4) Vehicle Repairs. If partial losses are settled on the basis of a written estimate prepared by or for the insurer, the insurer shall supply the insured a copy of the estimate upon which the settlement is based. The estimate prepared by or for the insurer shall be reasonable, in accordance with applicable policy provisions, and of an amount which will allow for repairs to be made in a

workmanlike manner. If the insured subsequently claims, based upon a written estimate which he or she obtains, that necessary repairs will exceed the written estimate prepared by or for the insurer, and differences remain unresolved during the course of the repair or negotiation process, the insurer shall:

(a) Pay the difference between the written estimate and a higher estimate obtained by the insured; or

(b) Promptly provide the insured with the name of at least one (1) repair shop in areas proximate to the local market area, including the closest major metropolitan areas within or without the state, that will make the repairs for the amount of the written estimate, not considering the cost of supplemental or additional repairs which may be uncovered as part of the repair process. The insurer shall assure that such repairs provided by such repairers designated by the insurer are performed in a workmanlike manner. The insurer shall maintain documentation of all such communications. If such communication is made by means other than writing, an appropriate notation of the communication shall be made in the claim file of the insurer and dated.

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

(6) When the insurer elects to repair and designates a specific repair shop for automobile repairs, the insurer shall cause the damaged automobile to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy and within a reasonable period of time.

(7) Towing. Unless the insurer has provided an insured with the name of a specific towing company or provides a roadside assistance program, prior to the insured's use of another towing company, the insurer shall pay any and all reasonable towing charges irrespective of the towing company used by the insured, subject to any applicable policy provisions.

(8) Storage. The insurer shall provide reasonable notice to an insured prior to termination of payment for reasonable automobile storage charges and documentation of the denial as required by rule 0780-01-05-.05. Such insurer shall provide reasonable time for the insured to remove the vehicle from storage prior to the termination of payment, subject to any applicable policy provisions.

(9) Betterment deductions are allowable only if the deductions:

(a) Reflect a measurable decrease in market value attributable to the poorer condition of, or prior damage to, the vehicle;

(b) Any deductions set forth in subparagraph 0780-01-05-.09(9)(a) above must be measurable, itemized, specified as to dollar amount, and documented in the claim file; and

(c) No insurer shall require the insured or first party claimant to supply parts for replacement.

Authority: T.C.A. §§ 56-2-301, 56-8-101 through 56-8-120, 56-8-105, 56-8-108, and 56-8-110.

0780-01-05-.10 Standards for Prompt, Fair and Equitable Settlements Applicable to Fire and Extended Coverage Type Policies with Replacement Cost Coverage.

(1) When the policy provides for the adjustment and settlement of first party losses based on replacement cost, the following shall apply:

(a) When a loss requires repair or replacement of an item or part, any consequential physical damage incurred in making such repair or replacement not otherwise excluded by the

policy, shall be included in the loss. The insured shall not have to pay for any cost except for betterment and any applicable deductible under the policy.

(b) When a loss requires replacement of items and the replaced items do not match in quality, color or size, the insurer shall replace items so as to conform to a reasonably uniform appearance according to the applicable policy provisions. This applies to interior and exterior losses. The insured shall not bear any cost over the applicable deductible, if any.

(2) Actual Cash Value:

(a) When the insurance policy provides for the adjustment and settlement of losses on an actual cash value basis on residential fire and extended coverage, the insurer shall determine actual cash value as follows: replacement cost of property at time of loss less depreciation, if any. Upon the insured's request, the insurer shall provide a copy of the claim file worksheets detailing any and all deductions for depreciation.

(a) In cases in which the insured's interest is limited because the property has nominal or no economic value, or a value disproportionate to replacement cost less depreciation, the determination of actual cash value as set forth above is not required. In such cases, the insurer shall provide, upon the insured's request, a written explanation of the basis for limiting the amount of recovery along with the amount payable under the policy.

Authority: T.C.A. §§ 56-2-301, 56-8-101 through 56-8-120, 56-8-108, and 56-8-110.

0780-01-05-.11 Standards for Prompt, Fair and Equitable Settlements Applicable to Life Insurers.

(1) Every insurer, upon receiving due notification of a claim filed, shall, within thirty (30) days of the notification, provide necessary claim forms, instructions and reasonable assistance so the first party claimant can properly comply with company requirements for filing a claim.

(2) Upon receipt of proof of loss from a first party claimant, the insurer shall begin any necessary investigation of the claim within thirty (30) days.

(3) The insurer's standards for claims processing shall be such that notice of claim or proof of loss submitted against one policy issued by that insurer shall fulfill the insured's obligation under any and all similar policies issued by that insurer and specifically identified by the insured to the insurer to the same degree that the same form would be required under any similar policy. If additional information is required to fulfill the insured's obligation under similar policies, the insurer may request the additional information. When it is apparent to the insurer that additional benefits would be payable under an insured's policy upon additional proofs of loss, the insurer shall communicate to and cooperate with the insured in determining the extent of the insurer's additional liability. Life insurers shall also operate in accordance with T.C.A. §§ 56-7-3401 through 56-7-3406 by searching for persons as defined in T.C.A. § 56-7-3403(8) against the social security death master file (DMF) and notifying beneficiaries about potential claims such persons may have against the company.

(4) The insurer shall affirm or deny liability on claims within a reasonable time and shall offer payment within thirty (30) days of affirmation of liability if the amount of the claim is determined and not in dispute. If portions of the claim are in dispute, the insurer shall tender payment for those portions that are not disputed within thirty (30) days.

(5) If a claim remains unresolved for sixty (60) days from the date proof of loss is received, the insurer shall provide the insured or, when applicable, the insured's beneficiary, or the insurance producer or other designated representative responsible for communicating with the beneficiary, with a reasonable explanation for the delay. If the investigation remains incomplete, the insurer shall, sixty (60) days from the date of initial notification and every sixty (60) days thereafter, send to the claimant a letter setting forth the reasons additional time is needed for investigation.

(6) The insurer shall acknowledge and respond within thirty (30) days to any written communications relating to a pending claim.

(7) When a claim is denied, written notice of denial shall be sent to the first party claimant within thirty (30) days of the determination. The insurer shall reference the policy provision, condition or exclusion upon which the denial is based.

(8) 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.

(9) No insurer shall indicate to a first party claimant on a payment draft, check or in any accompanying letter that said payment is "final" or "a release" of any claim unless the policy limit has been paid or there has been a compromise settlement agreed to by the first party claimant and the insurer as to coverage and amount payable under the policy.

(10) Pursuant to T.C.A. § 56-1-106, if the department makes a request for information from an insurer concerning a complaint filed against the insurer, the insurer must respond to the request within (30) days from the date the request is received by the insurer.

(11) If, after an insurer denies a claim in its entirety, the first party claimant objects in writing to such denial, the insurer shall notify the first party claimant or their legally authorized representative in writing that he or she may file a complaint with the department, Consumer Insurance Services, 500 James Robertson Parkway, Nashville, Tennessee 37243, 1-800-342-4029, or may submit the request for review electronically to that section's website, currently found at: https://tn.gov/commerce/topic/commerce-file-a-complaint.

Authority: T.C.A. §§ 56-1-106, 56-2-301, 56-7-3401 through 56-7-3406, 56-8-101 through 56-8-120, 56-8-105, 56-8-108, and 56-8-110.

0780-01-05-.12 Standards for Prompt, Fair and Equitable Settlements Applicable to Claims Made by Third Party Claimants.

Upon receipt of notice or notification of a claim or potential claim from a third party claimant, the insurer shall notify the third party claimant in writing that he or she may obtain information regarding any actions available to a third party claimant by contacting the department, Consumer Insurance Services, 500 James Robertson Parkway, Nashville, Tennessee 37243, 1-800-342-4029, or electronically to that section's website, currently found at: https://tn.gov/commerce/topic/commerce-file-a-complaint.

Authority: T.C.A. §§ 56-2-301, 56-8-101 through 56-8-120, 56-8-105, 56-8-108, and 56-8-110.

0780-01-05-.13 Penalties.

Violations of this Chapter shall be enforced against any person subject to the Tennessee Unfair Trade Practices and Unfair Claims Settlement Act of 2009, T.C.A. title 56, chapter 8, part 1, as provided therein, and any other applicable enforcement authority conferred by the insurance laws of Tennessee related to or incorporating violations of that Act, rules promulgated by the commissioner, or the subject matter addressed by this Chapter, including, but not limited to, T.C.A. §§ 56-2-305, 56-6-112, 56-6-410, 56-6-910, 56-7-3405, 56-8-103, 56-8-109, 56-8-111.

Authority: T.C.A. §§ 56-2-301, 56-2-305, 56-6-112, 56-6-410, 56-6-910, 56-7-3405, 56-8-101 through 56-8-120, 56-8-103, 56-8-108, 56-8-109, 56-8-110, and 56-8-111.

0780-01-05-.14 Severability.

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

Authority: T.C.A. §§ 56-2-301, 56-8-101 through 56-8-120, 56-8-108, and 56-8-110.

0780-01-05-.15 Waiver.

(1) Unless otherwise required by law, in the event of a catastrophic occurrence, as determined by the commissioner, in the State of Tennessee, the commissioner may waive the rules arising from, or otherwise affected by, the catastrophic occurrence as he or she deems necessary.

(2) The commissioner may waive these rules at his or her discretion in the event an insurer cannot comply or lacks the means to comply with these rules, unless statute mandates that no exception may be granted.

Authority: T.C.A. §§ 56-2-301, 56-8-101 through 56-8-120, 56-8-108, and 56-8-110.

0780-01-05-.16 Effective Date.

Insurers shall meet the requirements of this Chapter within six (6) months after the effective date of this Chapter. Policies, forms, and rates on file with the department must comply with this Chapter within six (6) months after the effective date of this Chapter. In the event a policy in existence six (6) months after the effective date of this Chapter does not comply, the policy may run through the end of its term, but it may not be renewed without first making the policy comply with this Chapter.

Authority: T.C.A. §§ 56-2-301, 56-2-305, 56-5-305, 56-7-2311, 56-8-101 through 56-8-120, 56-8-108, and 56-8-110.

* If a roll-call vote was necessary, the vote by the Agency on these rulemaking hearing rules was as follows:

Board Member	Aye	No	Abstain	Absent	Signature (if required)

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the Commissioner (board/commission/ other authority) on 06/06/2017 (mm/dd/yyyy), and is in compliance with the provisions of T.C.A. § 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on: 07/25/16

Rulemaking Hearing(s) Conducted on: (add more dates). 09/28/16

DENISE M. LEWIS
STATE OF TENNESSEE NOTARY PUBLIC
WILSON COUNTY, TENN.
My Commission Expires

Date: 6/6/17

Signature: Julie Mix McPeak

Name of Officer: Julie Mix McPeak

Title of Officer: Commissioner of the Department of Commerce and Insurance

Subscribed and sworn to before me on: 6/6/17

Notary Public Signature: Denise M Lewis

My commission expires on: 1/15/20

All rulemaking hearing rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

Herbert H. Slatery III

Herbert H. Slatery ~~III~~
Attorney General and Reporter

7/6/2017
Date

Department of State Use Only

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SECRETARY OF STATE
PUBLICATIONS

Filed with the Department of State on: 7/11/17

Effective on: 10/9/17

Tre Hargett

Tre Hargett
Secretary of State

Public Hearing Comments

One copy of a document containing responses to comments made at the public hearing must accompany the filing pursuant to T.C.A. § 4-5-222. Agencies shall include only their responses to public hearing comments, which can be summarized. No letters of inquiry from parties questioning the rule will be accepted. When no comments are received at the public hearing, the agency need only draft a memorandum stating such and include it with the Rulemaking Hearing Rule filing. Minutes of the meeting will not be accepted. Transcripts are not acceptable.

Comment 1
0780-01-05

It was commented that the words "or certificate" should be removed from these rules as, in some circumstances, the term certificate may reference evidence of insurance rather than a contract of insurance.

Response to Comment 1

The Insurance Division ("Division") disagrees with this comment as the term "certificate" is often used to describe a contract of insurance, and in such circumstances where such a certificate does not constitute a contract of insurance, these Rules would be inapplicable to the non-contemplated certificate. Furthermore, in circumstances, such as when a certificate is issued as coverage on a master insurance policy, inclusion of the term "certificate" in these Rules is necessary to encompass those insurance policies in these regulations. Accordingly, inclusion of the words "or certificate" does not contemplate any such certificate which is not an insurance policy, but is necessary to capture such policies which are described on their face as certificates. Additionally, the terms "policy" and "certificate" are defined at Tenn. Code Ann. § 56-8-102(11) as a "contract of insurance" and the term "insured" is defined as " . . . the party named on a policy or certificate . . ." at Tenn. Code Ann. § 56-8-102(8),

Comment 2
0780-01-05-.01

It was commented by two commenters that the word "personal" in reference to certificate of insurance in the Purpose rule of this this chapter is unclear.

Response to Comment 2

The Division agrees with this comment. The word "personal" has been removed from the rule.

Comment 3
0780-01-05-.04

It was commented that inclusion of the phrase "the following terms are defined unless the context requires otherwise[]" is concerning and defeats the purpose of including definitions in this chapter. The commenter expressed concern that the Division would use this reservation as a means by which it could apply its own definitions as it determined necessary under differing circumstances.

Response to Comment 3

This phrase referenced above is included in the introduction to the definitions for this Chapter to reserve the right to utilize other defined terms included in and limited to an individual rule of this chapter. The inclusion of this language is not intended to allow or assign the Division authority to arbitrarily attribute different definitions to terms. However, in the spirit of making the above outlined intention of the Division clear and to alleviate any further concerns, the language has been deleted and replaced with "As otherwise used in this Chapter, the following definitions apply unless otherwise specifically defined herein." This replacement language should adequately reflect the intent of the Division to allow for the use of other defined terms included within the Rule when applicable.

Comment 4
0780-01-05-.04(1)

It was commented by four commenters that the definition of "agent" is broad and may incorporate individuals not responsible for or involved in the claims handling process for an insurer. The commenters are concerned that individuals not responsible for or involved in the claims handling process may be held accountable for these rules, regardless of their involvement, or lack thereof, in the claims process. An example of the concern expressed by these commenters is that attorneys or vendors contracted only to make repairs could be considered an agent of an insurer in relation to the claims handling process, and thus responsible for compliance with this chapter.

Response to Comment 4

While these rules are intended to regulate the fairness of the actions of any individual engaged in the claims process, irrespective of whether the individual holds an insurance producer license, it is not the intent of this chapter to erroneously apply to agents of an insurer unrelated or lacking the requisite authority to be involved in the claims handling process. The term "agent" appeared in, and has since been removed from, two Rules, 0780-01-05-.04(13) and 0780-01-05-.06(2), which prohibit material misrepresentations of policy benefits, and require acknowledgement of a claim within thirty (30) days of receipt of notice of a claim. In both instances, the Department believes that the rule appropriately applies to an insurer, which under general agency laws would encompass their authorized representatives for the applicable duties, or an insurance producer. Therefore, removal of the term "agent" would not negatively impact the intent of the rule while at the same time alleviating all concerns that the rule would inappropriately apply to agents of an insurer that are not authorized nor traditionally associated with the representation of policy benefits or the claims handling process.

Comment 5
0780-01-05-.04(8)
(the comment was originally applicable to 0780-01-05-.04(9), however, due to subsequent amendments, the subdivisions of the rule were re-numbered.)

It was commented that the definition of "first party claimant" should be drafted to read ". . . . asserting a right *as an insured* to payment. . . ."

Response to Comment 5

The Division disagrees with this comment. These rules apply to policies issued to benefit either an insured directly or also a named beneficiary. Accordingly, a first party claimant could be the insured or a named beneficiary. The suggested edit in this comment unnecessarily limits the intent of this definition.

Comment 6
0780-01-05-.04(16)
(the comment was originally applicable to 0780-01-05-.04(17), however, due to subsequent amendments, the subdivisions of the rule were re-numbered.)

It was commented that the definition of "third party claimant" should be drafted to read ". . . . asserting a claim against any person *who is insured* under a policy or certificate of an insurer *which may be applicable to the third party claim.*"

Response to Comment 6

The Division disagrees with this comment. The definition of third party claimant is clear. Additions such as the suggested language create ambiguity as to which policies are subject to third party claims. It is important, for the protection of the public, to clearly identify third party claimants, and not to create confusion as to whom these rules may apply.

Comment 7
0780-01-05-.08(5)

It was commented that the need to give first party claimants notice of any applicable statute of limitations is unnecessary as such information is already included in the policy.

Response to Comment 7

The Division disagrees with this comment. The purpose of this rule is to ensure adequate protection is provided

to the consumer. Specific notice of the applicable statute of limitations to a first party claimant prior to its expiration, serves to better protect policyholders who may have misplaced or otherwise not ascertained such information from their policies. In addition, the notice serves as a reminder during the most relevant time that the consumer may lose their right to recovery, and resolves any confusion of rights the consumer may have experienced during the claims settlement process. Additionally, the information contained in each individual policy may vary, and providing this information after the insurer is on notice of a claim by their insured is not unreasonable.

Comment 8
0780-01-05-.10(1)(b)

It was commented that the phrase "uniform appearance," when referring to replacement of an item when the replacement item does not match the item being replaced under a property insurance policy, may be ambiguous. The commenter indicated that a reasonableness factor is already applied to replacement claims. It was further commented that there is concern this may also apply to repairs of damaged items.

Response to Comment 8

The Division disagrees with this comment. The term "reasonably uniform appearance" is sufficiently specific when read in the full context of Rule 0780-01-05-.10(1)(b), as that rule clarifies that this reasonableness assessment must be made when there is a deviation in quantity, color, or size of a replacement item. Read in context, it is clear when such a determination must be made, and a reasonableness assessment is already an industry standard. The Rule specifically states it applies in instances "[w]hen a loss requires replacement of items[,]" and does not contemplate repair claims.

Comment 9
0780-01-05-.11(2)

It was commented that "claimant" is used without reference to whether the rule applies to first or third party claimants, and claimant alone is not a defined term. It was requested that this provision be further clarified by including more specific terms as to whom the rule applies.

Response to Comment 9

The Rule governing life insurance policies is intended to apply to those persons that are legally authorized to submit a claim and receive benefits which could include the insured, the beneficiary or legal representative of the insured, including a member of the insured's immediate family designated by the insured, making a claim under a policy. In response to this comment, the Division has inserted the words "first party" before the word claimant, as this is a defined term within the rule that would encompass all the applicable persons and/or representatives that could submit a claim against a life insurance policy with legal authority to receive information and benefits from the insurer. The use of "first party claimant" instead of "claimant' is also consistent with the terminology used in the remainder of the Rule and Chapter.

Comment 10
0780-01-05-.12

It was commented by two commenters that there exists concern with the notification to third party claimants when the insurer receives notice of a claim or potential claim. It was commented that notifying third party claimants of actions available to them would pose a not insignificant burden and cost on the insurer. Further, there is concern that providing notice to a third party may jeopardize the duty which exists between the insurer and its insured.

Response to Comment 10

The Division disagrees with this comment. By including this language, previously agreed upon by both the Division and the industry in drafting these rules, it is the position of the Division that directing third party claimants, who may or may not understand the claims handing process, to a neutral party such as the Division does not jeopardize any existing duty between an insurer and its insured. Rather, by giving notice to the third party claimant of the Division, the insurer is able to direct any questions that may arise from such a third party claimant to a neutral outside party and negate the risk that the insurer may respond in a way that may jeopardize its relationship with its insured. Furthermore, the notice required under this rule only requires an insurer provide

publically available information, that an unsophisticated consumer may not know exists. (The Department website address in Rule 0780-01-05-.12 has been amended so as to direct the reader to the correct website.) Lastly, such notice to a third party claimant should not pose too substantial a burden on an insurer, as the Division hopes insurers are providing information to third parties that would facilitate a fair and equitable settlement of claims while still protecting the insured's best interests. It is possible, by providing this notice to third party claimants an insurer will cut down on its required communications with third party claimants, and ultimately, its costs.

Comment 11
0780-01-05-.12

The commenter questions whether an "action" for the purposes of this notification is a lawsuit. In the event this action is a lawsuit, the commenter expresses concerns that this notification requirement puts the Division in the position of providing legal advice to these third-party claimants.

Response to Comment 11

The Division disagrees with this comment. The Division does not give legal advice to any entity. Rather, through its Consumer Insurance Services Section, the Division already serves as an unbiased mediator between citizens of the State of Tennessee and insurers while strictly refraining from offering any legal advice. This notice will simply provide consumers with that information.

Comment 12
0780-01-05-.12

It was commented that there is concern as to when an insurer is required to give such notice to third party claimants. Specifically, it is asked whether the insurer must take affirmative steps to find any existing third parties. Additionally, in the event the police report redacts out the personal information of those involved, is the insurer required to seek out this third party in order to give notice?

Response to Comment 12

The Division disagrees with this comment. It is the position of the Division that such a notice is required to the extent the insurer is notified of or reasonably apprised of a third party claimant. Nothing in these rules directs an insurer to affirmatively seek out potential claimants whom the insurer is not notified of pursuant to the definition of "notification or notice of claim" at 0780-01-05-.04(12)

Comment 13
0780-01-05-.12

It was commented that giving notice to third party claimants of their right to contact the Division upon receipt of a third party claim may hinder the claims process. Commenter requests that such notice be required when the insurer denies liability of such a third party claimant's claim.

Response to Comment 13

The Division disagrees with this comment. It is the position of the Division that directing third party claimants, who may or may not understand the claims handing process, to a neutral party such as the Division will not hinder the claims handling process. Rather, by giving notice to the third party claimant of the Division as a resource, the insurer is able to direct any questions that may arise from such a third party claimant to a neutral outside party and avoid unnecessary delay in the claims handling process. The Division does not believe that waiting until the claim has been denied to provide such notice is appropriate, as the rule seeks to protect all impacted third party claimants which could include those still in negotiation with the insurer, that have not been denied.

Comment 14
0780-01-05-.16

It was commented by two commenters that the effective date language, which allows for a six-month period during which an insurer may prepare for compliance with this chapter, may not be afforded to policies which renew during the six-month time period following the effective date of the chapter. The commenter requests the effective date be changed to read ". . . . in the event a policy in existence *six months after* the effective date of this

Chapter does not comply. . . ."

Response to Comment 14

The Division agrees with this comment. Language has been added to make clear that those policies issued prior to the effective date of this Chapter, or within the six months following the effective date that an insurer's filings with the Department are not required to comply with the Chapter, may continue in force but may not be renewed six months following the effective date of the Chapter unless they comply with the standards set forth.

Regulatory Flexibility Addendum

Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rulemaking process, all agencies shall conduct a review of whether a proposed rule or rule affects small business.

The Department of Commerce and Insurance has considered whether the proposed rules in these Rulemaking Hearing Rules are such that they will have an economic impact on small businesses (businesses with fifty (50) or fewer employees). The proposed rules are not anticipated to have a significant impact on small businesses. Tenn. Code Ann. §§ 56-2-301, 56-8-101 through 56-8-120, 56-8-108, and 56-8-110 authorize the Commissioner to promulgate rules in order to protect consumers by setting forth the minimum standards for investigation and disposition of claims arising out of contracts of insurance. The proposed rules establish the minimum standards for investigation and disposition of claims arising out of contracts of insurance in the State of Tennessee.

The outcome of the analysis set forth in Tenn. Code Ann. § 4-5-403 is as follows:

(1) The proposed rules will only apply to insurance companies and persons subject to title 56, chapter 8, part 1, involved in investigating and disposing of claims arising out of contracts of insurance. While there may be some insurance companies considered to be small business affected by these rules, it is estimated that this number is small.

(2) The projected reporting, recordkeeping, and other administrative costs associated with compliance with this proposed rule are not anticipated to increase from that which exists under current practices.

(3) The effect on small businesses is minimal. The proposed rules will positively affect consumers by affording them added protections in the insurance claims handling process, and will only affect those insurance companies and persons subject to title 56, chapter 8, part 1, investigating and disposing of claims arising out of contracts of insurance.

(4) There are no alternative methods to make the proposed rule less costly, less intrusive, or less burdensome.

(5) These rules reflect the National Association of Insurance Commissioners ("NAIC") model on unfair claims settlement practices in collaboration with the insurance industry in the State of Tennessee.

(6) Only insurance companies and persons subject to title 56, chapter 8, part 1, investigating and disposing of claims arising out of contracts of insurance are required to comply with this rule. Exempting any company or person from these proposed rules would place Tennessee residents at a risk of being affected by disparate and unfair claims handling practices within the State of Tennessee.

Impact on Local Governments

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 "any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments." (See Public Chapter Number 1070 (http://state.tn.us/sos/acts/106/pub/pc1070.pdf) of the 2010 Session of the General Assembly)

This rule will not have an impact on local governments.

Additional Information Required by Joint Government Operations Committee

All agencies, upon filing a rule, must also submit the following pursuant to T.C.A. § 4-5-226(i)(1).

(A) A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

These rules protect consumers by setting forth the minimum standards for investigation and disposition of claims arising out of contracts of insurance. These rules provide standards for prompt, fair, and equitable settlements, file and record documentation, and communication timelines.

(B) A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

Tenn. Code Ann. § 56-2-301 authorizes the Commissioner of the Department of Commerce and Insurance to promulgate rules and regulations for the purpose of regulating the writing of various kinds and types of insurance. Tenn. Code Ann. §§ 56-8-101 et seq. ("Tennessee Unfair Trade Practices and Unfair Claims Settlement Act of 2009"), state the purpose to regulate trade and claims settlement practices in the business of insurance. Specifically, Tenn. Code Ann. §§ 56-8-108 and 56-8-110 authorize the Commissioner to promulgate rules and regulations declaring certain acts to be unfair trade practices, unfair methods of competition, or deceptive acts or practices in the business of insurance.

(C) Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

These rules will affect any insurance companies and persons subject to title 56, chapter 8, part 1, involved in investigating and disposing of claims arising out of contracts of insurance.

(D) Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule or the necessity to promulgate the rule;

Tennessee Attorney General Opinion No. 08-84 addressed the constitutionality of The Tennessee Unfair Trade Practices and Unfair Claims Settlement Act of 2009 prior to its enactment. Specifically, it addressed whether the proposed legislation unlawfully delegated legislative authority to the Commissioner of Commerce and Insurance. The opinion concluded that the General Assembly is authorized to delegate to an administrative agency the authority to implement the expressed policy of particular statutes, including the power to promulgate rules and regulations and that broad authority is necessary to permit the Commissioner to exercise his or her expertise and flexibility to deal with complex and changing conditions within the insurance industry.

(E) An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars ($500,000), whichever is less;

None.

(F) Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

Michael Humphreys, Assistant Commissioner for Insurance; Rachel Jrade-Rice, Director of Insurance; Brian Hoffmeister, Director of Policy Analysis; Vickie Trice, Director of Consumer Insurance Services.

(G) Identification of the appropriate agency representative or representatives who will explain the rule at a scheduled meeting of the committees;

Kaycee Wolf, Chief Counsel for Insurance, Securities, and TennCare Oversight and Jenny Taylor, Assistant General Counsel for Insurance

Davy Crockett Tower, 8th Floor, 500 James Robertson Parkway, Nashville, Tennessee 37243; 615-770-5305; jenny.taylor@tn.gov.

(l) Any additional information relevant to the rule proposed for continuation that the committee requests.

None.

New

Chapter 0780-01-05
Unfair Claims Settlement Practices

Table of Contents

0780-01-05-.01 Purpose.

The purpose of this Chapter is to set forth minimum standards for the investigation and disposition of claims arising under contracts or certificates of insurance issued to residents of the state. It is not intended to cover claims involving workers' compensation or health care. The various provisions of this Chapter are intended to define procedures and practices which constitute unfair claims practices as determined by the commissioner. Nothing herein shall be construed either to create or to imply a private cause of action for violation of this Chapter.

Authority: T.C.A. §§ 56-2-301, 56-8-101 through 56-8-120, 56-8-101(c), 56-8-105, 56-8-108, and 56-8-110.

0780-01-05-.02 Scope.

This Chapter applies to all insurers or persons subject to title 56, chapter 8, part 1, that are authorized to sell, transact, or are otherwise engaged in the business of insurance in this state. Specifically, rules 0780-01-05-.06 through .10 only apply to property and casualty insurers doing business in this state. Rule 0780-01-05-.11 only applies to life insurers doing business in this state.

Authority: T.C.A. §§ 56-2-301, 56-8-101 through 56-8-120, 56-8-108, and 56-8-110.

0780-01-05-.03 Authority.

This Chapter is issued pursuant to the authority vested in the commissioner pursuant to T.C.A. §§ 56-8-108 and 56-8-110, the Tennessee Unfair Trade Practices and Unfair Claims Settlement Act

of 2009, T.C.A. title 56, chapter 8, part 1, and other authority conferred by the insurance laws of Tennessee to regulate lines of insurance.

Authority: T.C.A. §§ 56-2-301, 56-8-101 through 56-8-120, 56-8-108, and 56-8-110.

0780-01-05-.04 Definitions.

All definitions contained in the Tennessee Unfair Trade Practices and Unfair Claims Settlement Act of 2009, T.C.A. title 56, chapter 8, part 1, are hereby incorporated by reference. As otherwise used in this Chapter, the following definitions apply unless otherwise specifically defined herein:

(1) "Beneficiary" means the party entitled to receive the proceeds or benefits occurring under the policy of the insured;

(2) "Claim" means:

(a) 1. An oral, written, or electronic submission for payment that is filed by an insured,

on behalf of an insured, or by a third party where the insurer accepts such claims, in accordance with the insurer's reasonable submission standards; and

2. Is sufficient to reasonably establish contractual liability for payment on the part of the insurer;

(b) For the purposes of T.C.A. § 56-8-105, a "claim" does not mean an inquiry by an insured as to the existence of coverage or how a potential claim may affect future premiums or renewability of coverage;

(3) "Claim file" means any retrievable electronic file, paper file, or combination of both, relative to a specific claim made by or on behalf of a claimant with an insurer;

(4) "Commissioner" means the commissioner of the department of commerce and insurance;

(5) "Days" means calendar days unless otherwise noted;

(6) "Department" means the department of commerce and insurance;

(7) "Documentation" or "to be documented" includes, but is not limited to, all pertinent communications, transactions, notes, work papers, claim forms, bills and explanation of benefits forms relative to the claim;

(8) "First party claimant" means an individual, corporation, association, partnership or other legal entity asserting a right to payment directly against an insurer under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by the policy or contract;

(9) "Inquiry" means any communication to an insurance company by an insured or by an insurance producer on behalf of an insured, regarding general terms and conditions of the insured's personal residential property policy, including a communication concerning whether an insured's personal residential property policy provides coverage for a type of event or the process for filing a claim;

(10) "Insurance producer" or "producer" means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance under title 56, chapter 6, part 1;

(11) "Investigation" means all activities of an insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy or insurance contract;

(12) "Notification of claim" or "notice of claim" means any notification, in writing or other means acceptable under the terms of an insurance policy, to an insurer or its producer by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim;

(13) "Personal residential property policy" means a homeowners insurance policy or a policy otherwise described in T.C.A. §§ 56-5-302(7)(A) and (B);

(14) "Proof of loss" means written proofs, such as claim forms, or other reasonable evidence of the claim that is required of insureds or beneficiaries submitting the claims;

(15) "Reasonable explanation" means information sufficient to enable the insured or beneficiary to compare the allowable benefits with policy provisions and determine whether proper payment has been made;

(16) "Third party claimant" means any person asserting a claim against any person under a policy or certificate of an insurer; and

(17) "Written communication" includes all correspondence, regardless of source or type, that is materially related to the handling of the claim. Written communication also includes electronic mail (email) when requested by the claimant and when accepted by the insurer. Written communication does not include any privileged communication that is prepared by an attorney employed or retained by an insurer, including, but not limited to, work product or legal opinions.

Authority: T.C.A. §§ 56-2-301, 56-5-302(7)(A) and (B), 56-6-102, 56-7-3403, 56-8-101 through 56-8-120, 56-8-102, 56-8-108, and 56-8-110.

0780-01-05-.05 File and Record Documentation.

Each insurer's claim files for policies or certificates are subject to examination by the commissioner or his or her duly appointed designees. To aid in such examination:

(1) The insurer shall maintain claim data that is accessible and retrievable for examination. An insurer shall be able to provide the claim number, line of coverage, date of loss, date of payment of the claim, date of denial or date closed without payment. This data must be available for all open and closed claim files for the current year and the five (5) preceding years.

(2) Documentation shall be contained in each claim file in order to permit reconstruction of the insurer's activities relative to each claim.

(3) Each relevant document within the claim file shall be noted as to date received, date processed, or date mailed.

(4) For those insurers that do not maintain hard copy files, claim files must be accessible from cathode ray tube (CRT), micrographics, magnetic tape, electronic databases, or other electronic storage formats, and be capable of duplication to hard copy.

Authority: T.C.A. §§ 56-1-103, 56-1-106, 56-1-408, 56-1-409, 56-1-410, 56-2-301, 56-8-101 through 56-8-120, 56-8-104(10), 56-8-107, 56-8-108, and 56-8-110.

0780-01-05-.06 Misrepresentation of Policy Provisions.

(1) No insurer shall fail to fully disclose, upon request, to first party claimants all pertinent benefits, coverages or other provisions of a policy or contract under which a claim is presented.

(2) No producer shall misrepresent to named insureds benefits, coverages or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim.

(3) A claim shall not be denied on the basis of failure to provide access to property unless provided for under the terms of the policy and documented in the claim file.

(4) No insurer shall deny a claim based upon the failure of a first party claimant to give written notice of loss within a specified time limit unless the written notice is a written policy condition.

(5) No insurer shall indicate to a first party claimant on a payment draft, check, or in any accompanying letter that said payment is "final" or "a release" of any claim unless the policy limit has been paid or there has been a compromise settlement agreed to by the first party claimant and the insurer as to coverage and amount payable under the contract.

(6) No insurer shall issue checks or drafts in partial settlement of a loss or claim under a specific coverage that contains language purporting to release the insurer or its insured from total liability.

Authority: T.C.A. §§ 56-2-301, 56-8-101 through 56-8-120, 56-8-104, 56-8-105, 56-8-108, and 56-8-110.

0780-01-05-.07 Failure to Acknowledge Pertinent Communications.

(1) Every insurer, upon receiving notification of a claim, shall, within thirty (30) days, acknowledge the receipt of such notice unless payment is made within that period of time. If an acknowledgement is made by means other than writing, an appropriate notation of the acknowledgement shall be made in the claim file of the insurer and dated.

(2) Pursuant to T.C.A. § 56-1-106, if the department makes a request for information from an insurer concerning a complaint filed against the insurer, the insurer must respond to the request within thirty (30) days from the date the request is received by the insurer.

(3) An appropriate reply shall be made within thirty (30) days on all other pertinent communications from a first party claimant which reasonably suggest that a response is expected.

(4) Every insurer, upon receiving notification of claim, shall promptly provide necessary claim forms, instructions and reasonable assistance so that first party claimants can comply with the policy conditions and the insurer's reasonable requirements. Compliance with this paragraph within thirty (30) days of notification of a claim shall constitute compliance with paragraph 0780-01-05-.07(1).

Authority: T.C.A. §§ 56-1-106, 56-2-301, 56-8-101 through 56-8-120, 56-8-105, 56-8-108, and 56-8-110.

0780-01-05-.08 Standards for Prompt, Fair and Equitable Settlements Applicable to Property and Casualty Insurers.

(1) Within sixty (60) days after receipt by the insurer of properly completed and executed proofs of loss and such information or documents required under the policy, the first party

claimant shall be advised of the acceptance or denial of liability for the claim by the insurer. No insurer shall deny a claim without providing a basis for the denial. Upon request, any denial must be given to the first party claimant in writing and the claim file of the insurer shall contain documentation of the denial as required by rule 0780-01-05-.05.

(a) Where there is a reasonable basis supported by specific information available for review by the department that the first party claimant has fraudulently caused, contributed to, or misrepresented the loss, the insurer is relieved from the requirements of paragraph 0780-01-05-.08(1); provided, however, that the first party claimant shall be advised of the acceptance or denial of liability for the claim within a reasonable time for full investigation after receipt by the insurer of a properly completed and executed proof of loss.

(2) If the insurer needs more time to determine whether liability for a first party claim should be accepted or denied, it shall so notify the first party claimant within sixty (60) days after receipt of the proofs of loss and such information or documents required under the policy, giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, sixty (60) days from the initial notification and every sixty (60) days thereafter, send to the first party claimant a letter setting forth the reasons additional time is needed for investigation.

(a) Where there is a reasonable basis supported by specific information available for review by the department for suspecting that the first party claimant has fraudulently caused, contributed to, or misrepresented the loss, the insurer is relieved from the requirements of paragraph 0780-01-05-.08(2); provided, however, that the claimant shall be advised of the acceptance or denial of liability for the claim by the insurer within a reasonable time for full investigation after receipt by the insurer of a properly completed and executed proof of loss.

(3) The insurer shall, within thirty (30) days after concluding a coverage investigation, notify the first party claimant of the findings of the investigation. Paragraphs 0780-01-05-.08(1) and (2) shall apply at the time the notice of investigation closure is sent.

(4) Insurers shall not fail to settle first party claims on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions.

(5) Insurers shall give notice of an applicable statute of limitations to first party claimants at least thirty (30) days before the date on which such statute of limitations may expire.

(6) The insurer shall tender payment within thirty (30) days of affirmation of liability, if the amount of the claim is determined and not in dispute, unless the policyholder does not want payment within thirty (30) days.

(7) No insurer shall request or require any insured to submit to a polygraph examination unless authorized under the applicable insurance contracts and state law.

(8) If, after an insurer denies a claim in its entirety, the first party claimant objects in writing to such denial, the insurer shall notify the first party claimant in writing that he or she may file a complaint with the department, Consumer Insurance Services, 500 James Robertson Parkway, Nashville, Tennessee 37243, 1-800-342-4029, or may submit the complaint request for review electronically to that section's complaint link for insurance complaints, currently found at: https://tn.gov/commerce/topic/commerce-file-a-complaint.

(9) An insurer shall notify a policyholder of his or her right to choose a vendor to complete repairs of damages covered under the policy, unless use of a specified vendor is

provided pursuant to the terms of the policy. If a notice is made by means other than writing, an appropriate notation of the notice shall be made in the claim file of the insurer and dated.

(10) No insurer shall cancel a personal residential property policy in effect for sixty (60) days or more, if the sole reason for the cancellation of the policy is that a claim is pending with the insurer.

(11) Pursuant to T.C.A. § 56-7-113, no insurance company shall increase a premium or cancel a personal residential property policy solely on the basis of an inquiry or inquiries by an insured regarding the insured's personal residential property policy or a loss under the policy.

Authority: T.C.A. §§ 56-2-201, 56-2-202, 56-2-301, 56-7-113, 56-8-101 through 56-8-120, 56-8-105, 56-8-108, and 56-8-110.

0780-01-05-.09 Standards for Prompt, Fair and Equitable Settlements Applicable to Automobile Insurance.

(1) When the insurance policy provides for the adjustment and settlement of first party automobile total losses on the basis of actual cash value or replacement with another of like kind and quality, one of the following methods shall apply at the discretion of the insurer:

(a) The insurer may elect to offer a replacement automobile that is at least comparable in that it will be by the same manufacturer, same or newer year, similar body style, similar options and mileage as the insured vehicle and in as good or better overall condition and available for inspection at a licensed dealer within a reasonable distance of the insured's residence. The insurer shall pay all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of the automobile, paid at no cost other than any deductible provided in the policy. The offer and any rejection thereof must be documented in the claim file.

(b) The insurer may elect a cash settlement based upon the actual cost, less any deductible provided in the policy, to purchase a comparable automobile including all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of a comparable automobile. Such cost may be derived from:

1. The cost of two or more comparable automobiles in the local market area when comparable automobiles are available or were available within the last ninety (90) days to consumers in the local market area; or

2. The cost of two (2) or more comparable automobiles in areas proximate to the local market area, including the closest major metropolitan areas within or without the state, that are available or were available within the last ninety (90) days to consumers when comparable automobiles are not available in the local market area pursuant to part 0780-01-05-.09(1)(b)1. above; or

3. One (1) of two (2) or more quotations obtained by the insurer from two (2) or more licensed dealers located within the local market area when the cost of comparable automobiles are not available pursuant to parts 0780-01-05-.09(1)(b)1. and (1)(b)2. above; or

4. Any source for determining statistically valid fair market values that meet all of the following criteria:

(i) The source shall give primary consideration to the values of vehicles in the local market area and may consider data on vehicles outside the area;

(ii) The source's database shall produce values for at least eighty-five percent (85%) of all makes and models for the last fifteen (15) model years, taking into account the values of all major options for such vehicles; and

(iii) The source shall produce fair market values based on current data available from the area surrounding the location where the insured vehicle was principally garaged or a necessary expansion of parameters (such as time and area) to assure statistical validity.

(c) When a first party claimant's automobile total loss is settled on a basis which deviates from the methods described in subparagraphs 0780-01-05-.09(1)(a) and (1)(b), the deviation must be supported by documentation giving particulars of the automobile condition. Any deductions from the cost, including deduction for salvage, must be as specific as reasonably possible, and specific and appropriate as to dollar amount, and shall be documented in the claim file as required by rule 0780-01-05-.05. The basis for the settlement shall be fully explained to the first party claimant.

(2) Insurers shall not require a first party claimant to travel an unreasonable distance either to inspect a replacement automobile, to obtain a repair estimate or to have the automobile repaired at a specific repair shop.

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

(4) Vehicle Repairs. If partial losses are settled on the basis of a written estimate prepared by or for the insurer, the insurer shall supply the insured a copy of the estimate upon which the settlement is based. The estimate prepared by or for the insurer shall be reasonable, in accordance with applicable policy provisions, and of an amount which will allow for repairs to be made in a workmanlike manner. If the insured subsequently claims, based upon a written estimate which he or she obtains, that necessary repairs will exceed the written estimate prepared by or for the insurer, and differences remain unresolved during the course of the repair or negotiation process, the insurer shall:

(a) Pay the difference between the written estimate and a higher estimate obtained by the insured; or

(b) Promptly provide the insured with the name of at least one (1) repair shop in areas proximate to the local market area, including the closest major metropolitan areas within or without the state, that will make the repairs for the amount of the written estimate, not considering the cost of supplemental or additional repairs which may be uncovered as part of the repair process. The insurer shall assure that such repairs provided by such repairers designated by

the insurer are performed in a workmanlike manner. The insurer shall maintain documentation of all such communications. If such communication is made by means other than writing, an appropriate notation of the communication shall be made in the claim file of the insurer and dated.

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

(6) When the insurer elects to repair and designates a specific repair shop for automobile repairs, the insurer shall cause the damaged automobile to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy and within a reasonable period of time.

(7) Towing. Unless the insurer has provided an insured with the name of a specific towing company or provides a roadside assistance program, prior to the insured's use of another towing company, the insurer shall pay any and all reasonable towing charges irrespective of the towing company used by the insured, subject to any applicable policy provisions.

(8) Storage. The insurer shall provide reasonable notice to an insured prior to termination of payment for reasonable automobile storage charges and documentation of the denial as required by rule 0780-01-05-.05. Such insurer shall provide reasonable time for the insured to remove the vehicle from storage prior to the termination of payment, subject to any applicable policy provisions.

(9) Betterment deductions are allowable only if the deductions:

(a) Reflect a measurable decrease in market value attributable to the poorer condition of, or prior damage to, the vehicle;

(b) Any deductions set forth in subparagraph 0780-01-05-.09(9)(a) above must be measurable, itemized, specified as to dollar amount, and documented in the claim file; and

(c) No insurer shall require the insured or first party claimant to supply parts for replacement.

Authority: T.C.A. §§ 56-2-301, 56-8-101 through 56-8-120, 56-8-105, 56-8-108, and 56-8-110.

0780-01-05-.10 Standards for Prompt, Fair and Equitable Settlements Applicable to Fire and Extended Coverage Type Policies with Replacement Cost Coverage.

(1) When the policy provides for the adjustment and settlement of first party losses based on replacement cost, the following shall apply:

(a) When a loss requires repair or replacement of an item or part, any consequential physical damage incurred in making such repair or replacement not otherwise excluded by the policy, shall be included in the loss. The insured shall not have to pay for any cost except for betterment and any applicable deductible under the policy.

(b) When a loss requires replacement of items and the replaced items do not match in quality, color or size, the insurer shall replace items so as to conform to a reasonably uniform appearance according to the applicable policy provisions.

This applies to interior and exterior losses. The insured shall not bear any cost over the applicable deductible, if any.

(2) Actual Cash Value:

(a) When the insurance policy provides for the adjustment and settlement of losses on an actual cash value basis on residential fire and extended coverage, the insurer shall determine actual cash value as follows: replacement cost of property at time of loss less depreciation, if any. Upon the insured's request, the insurer shall provide a copy of the claim file worksheets detailing any and all deductions for depreciation.

(a) In cases in which the insured's interest is limited because the property has nominal or no economic value, or a value disproportionate to replacement cost less depreciation, the determination of actual cash value as set forth above is not required. In such cases, the insurer shall provide, upon the insured's request, a written explanation of the basis for limiting the amount of recovery along with the amount payable under the policy.

Authority: T.C.A. §§ 56-2-301, 56-8-101 through 56-8-120, 56-8-108, and 56-8-110.

0780-01-05-.11 Standards for Prompt, Fair and Equitable Settlements Applicable to Life Insurers.

(1) Every insurer, upon receiving due notification of a claim filed, shall, within thirty (30) days of the notification, provide necessary claim forms, instructions and reasonable assistance so the first party claimant can properly comply with company requirements for filing a claim.

(2) Upon receipt of proof of loss from a first party claimant, the insurer shall begin any necessary investigation of the claim within thirty (30) days.

(3) The insurer's standards for claims processing shall be such that notice of claim or proof of loss submitted against one policy issued by that insurer shall fulfill the insured's obligation under any and all similar policies issued by that insurer and specifically identified by the insured to the insurer to the same degree that the same form would be required under any similar policy. If additional information is required to fulfill the insured's obligation under similar policies, the insurer may request the additional information. When it is apparent to the insurer that additional benefits would be payable under an insured's policy upon additional proofs of loss, the insurer shall communicate to and cooperate with the insured in determining the extent of the insurer's additional liability. Life insurers shall also operate in accordance with T.C.A. §§ 56-7-3401 through 56-7-3406 by searching for persons as defined in T.C.A. § 56-7-3403(8) against the social security death master file (DMF) and notifying beneficiaries about potential claims such persons may have against the company.

(4) The insurer shall affirm or deny liability on claims within a reasonable time and shall offer payment within thirty (30) days of affirmation of liability if the amount of the claim is determined and not in dispute. If portions of the claim are in dispute, the insurer shall tender payment for those portions that are not disputed within thirty (30) days.

(5) If a claim remains unresolved for sixty (60) days from the date proof of loss is received, the insurer shall provide the insured or, when applicable, the insured's beneficiary, or the insurance producer or other designated representative responsible for communicating with the beneficiary, with a reasonable explanation for the delay. If the investigation remains incomplete, the insurer shall, sixty (60) days from the date of initial notification

and every sixty (60) days thereafter, send to the claimant a letter setting forth the reasons additional time is needed for investigation.

(6) The insurer shall acknowledge and respond within thirty (30) days to any written communications relating to a pending claim.

(7) When a claim is denied, written notice of denial shall be sent to the first party claimant within thirty (30) days of the determination. The insurer shall reference the policy provision, condition or exclusion upon which the denial is based.

(8) 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.

(9) No insurer shall indicate to a first party claimant on a payment draft, check or in any accompanying letter that said payment is "final" or "a release" of any claim unless the policy limit has been paid or there has been a compromise settlement agreed to by the first party claimant and the insurer as to coverage and amount payable under the policy.

(10) Pursuant to T.C.A. § 56-1-106, if the department makes a request for information from an insurer concerning a complaint filed against the insurer, the insurer must respond to the request within (30) days from the date the request is received by the insurer.

(11) If, after an insurer denies a claim in its entirety, the first party claimant objects in writing to such denial, the insurer shall notify the first party claimant or their legally authorized representative in writing that he or she may file a complaint with the department, Consumer Insurance Services, 500 James Robertson Parkway, Nashville, Tennessee 37243, 1-800-342-4029, or may submit the request for review electronically to that section's website, currently found at: https://tn.gov/commerce/topic/commerce-file-a-complaint.

Authority: T.C.A. §§ 56-1-106, 56-2-301, 56-7-3401 through 56-7-3406, 56-8-101 through 56-8-120, 56-8-105, 56-8-108, and 56-8-110.

0780-01-05-.12 Standards for Prompt, Fair and Equitable Settlements Applicable to Claims Made by Third Party Claimants.

Upon receipt of notice or notification of a claim or potential claim from a third party claimant, the insurer shall notify the third party claimant in writing that he or she may obtain information regarding any actions available to a third party claimant by contacting the department, Consumer Insurance Services, 500 James Robertson Parkway, Nashville, Tennessee 37243, 1-800-342-4029, or electronically to that section's website, currently found at: https://tn.gov/commerce/topic/commerce-file-a-complaint.

Authority: T.C.A. §§ 56-2-301, 56-8-101 through 56-8-120, 56-8-105, 56-8-108, and 56-8-110.

0780-01-05-.13 Penalties.

Violations of this Chapter shall be enforced against any person subject to the Tennessee Unfair Trade Practices and Unfair Claims Settlement Act of 2009, T.C.A. title 56, chapter 8, part 1, as provided therein, and any other applicable enforcement authority conferred by the insurance laws of Tennessee related to or incorporating violations of that Act, rules promulgated by the commissioner, or the subject matter addressed by this Chapter, including, but not limited to, T.C.A. §§ 56-2-305, 56-6-112, 56-6-410, 56-6-910, 56-7-3405, 56-8-103, 56-8-109, 56-8-111.

Authority: T.C.A. §§ 56-2-301, 56-2-305, 56-6-112, 56-6-410, 56-6-910, 56-7-3405, 56-8-101 through 56-8-120, 56-8-103, 56-8-108, 56-8-109, 56-8-110, and 56-8-111.

0780-01-05-.14 Severability.

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

Authority: T.C.A. §§ 56-2-301, 56-8-101 through 56-8-120, 56-8-108, and 56-8-110.

0780-01-05-.15 Waiver.

(1) Unless otherwise required by law, in the event of a catastrophic occurrence, as determined by the commissioner, in the State of Tennessee, the commissioner may waive the rules arising from, or otherwise affected by, the catastrophic occurrence as he or she deems necessary.

(2) The commissioner may waive these rules at his or her discretion in the event an insurer cannot comply or lacks the means to comply with these rules, unless statute mandates that no exception may be granted.

Authority: T.C.A. §§ 56-2-301, 56-8-101 through 56-8-120, 56-8-108, and 56-8-110.

0780-01-05-.16 Effective Date.

Insurers shall meet the requirements of this Chapter within six (6) months after the effective date of this Chapter. Policies, forms, and rates on file with the department must comply with this Chapter within six (6) months after the effective date of this Chapter. In the event a policy in existence six (6) months after the effective date of this Chapter does not comply, the policy may run through the end of its term, but it may not be renewed without first making the policy comply with this Chapter.

Authority: T.C.A. §§ 56-2-301, 56-2-305, 56-5-305, 56-7-2311, 56-8-101 through 56-8-120, 56-8-108, and 56-8-110.